Right to refuse treatment, and court-ordered treatment

"There is nothing about pregnancy or the onset of the labor process which automatically renders a woman incapable of rational thought or unable to participate in competent decision making." *Bankert by Bankert v. United States*, 937 F. Supp. 1169, 1174 (D. Md. 1996). See also *In re Fetus Brown*, 689 N.E.2d 397, 400 (Ill. App. Ct. 1997) (holding the "State may not override a pregnant woman's competent treatment decisions, including refusal of recommended invasive medical procedures, to potentially save the life of the viable fetus"); *In re A.C.*, 573 A.2d 1235 (D.C. Cit. 1990) (holding "in virtually all cases the question of what is to be done is to be decided by the patient — the pregnant woman — on behalf of herself and the fetus").

In addition to the right to refuse medical care which is recognized by the Supreme Court, a parent's constitutional right extends to the right to the custody and control of her children. *See Meyer v. Nebraska*, 262 U.S. 390 (1923); *Troxel v. Granville*, 530 U.S. 57, 65 (2000) ("The liberty interest . . . of parents in the care, custody, and control of their children . . . is perhaps the oldest of the fundamental liberty interests recognized by this Court"); *Moriarty v. Bradt*, 177 NJ. 84, 101 (2003) ("The right to rear one's children . . . has been identified as a fundamental liberty interest protected by the Due Process Clause of the Fourteenth Amendment").

These legal principles are reinforced by an opinion of the American College of Obstetricians and Gynecologists. ACOG is an organization largely responsible for setting the standard of care for obstetricians in the United States. Committee Opinion No. 664 specifically deals with the right to refuse treatment in the context of pregnancy. It states, "Pregnancy is not an exception to the principle that a decisionally capable patient has the right to refuse treatment, even treatment needed to maintain life. Therefore, a decisionally capable pregnant woman's decision to refuse recommended medical or surgical interventions should be respected." The opinion sets out other ethical considerations that underlie a situation where a pregnant woman wishes to decline certain medical procedures.

In certain extreme circumstances, courts have upheld a decision to order a pregnant woman to undergo a Cesarean section to protect the life of her unborn child. *Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr., Inc.*, 66 F. Supp. 2d 1247, 1254 (N.D. Fla. 1999), in support of its position that Ms. Burton may be legally compelled to undergo a Cesarean section. That case – which was decided almost 20 years ago – upheld a court-ordered Cesarean section for a mother who was in the process of attempting vaginal delivery after a Cesarean section, at her house, without a physician either participating or standing by. The woman's request to the hospital was not that she

be allowed to deliver vaginally at the hospital but instead that the hospital provide an IV so that she could return home to deliver there. She did so in spite of the fact that "Every physician she contacted advised her that, because of the type of caesarean section she had undergone previously, vaginal delivery was not an acceptable option." *Id.* When the plaintiff initially refused to consent to a Cesarean section, "hospital officials set about securing additional opinions from board certified obstetricians [… who] separately concurred in the determination that a caesarean was medically necessary." While the hospital obtained those opinions, the plaintiff left the hospital surreptitiously.

In *Jefferson v. Griffin Spalding Cty. Hosp. Auth.*, 247 Ga. 86, 86 (1981), the Georgia Supreme Court declined to stay a superior court's order that a mother be compelled to undergo a Cesarean section if she appeared at the hospital seeking treatment. The underlying medical condition was placenta previa, and the superior court found that there was a 99% chance that the child would die if the mother attempted a vaginal delivery, and a 99% chance the child would survive if delivered by Cesarean section. *Id.* The Supreme Court upheld the order that required the woman "to submit to a Cesarean section and related procedures considered necessary by the attending physician to sustain the life of this child[.]" Nevertheless, the Court recognized that the Cesarean section was only necessary if a further test indicated that the placenta was "still blocking the child's passage[.]" *Id.* at 89.

Laws requiring hospitals to treat women in labor

Under O.C.G.A. § 31-8-42, a hospital has an obligation to provide care to a woman in active labor. Similarly, under federal law, the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd, requires hospitals receiving certain federal funds to provide stabilizing treatment for any woman who presents in active labor. Under subsection (e)(3)(B) of the Act, the term "stabilized" in the context of a woman in labor means "that the woman has delivered (including the placenta)."

Cases regarding the corporate practice of medicine

A corporation cannot be licensed to practice medicine in Georgia. "By statute, the physician is the only one empowered to practice medicine." *Cobb Cty.-Kennestone Hosp. Auth. v. Prince*, 242 Ga. 139, 144 (1978) (citing Code Ann. § 84-901, the predecessor to O.C.G.A. § 43-34-21). The ability to practice medicine belongs to doctors, and a doctor's privileges to practice at a hospital mean the "privilege to practice his profession." *Dunbar v. Hosp. Auth. of Gwinnett County*, 227 Ga. 534, 540 (1971).

Under O.C.G.A. § 43-34-21, "practicing medicine" means "the suggestion, recommendation, or prescribing of any form of treatment for the intended palliation, relief, or cure of any physical, mental, or functional ailment or defect of any person with the intention of receiving therefor, either directly or indirectly, any fee, gift, or compensation whatsoever[.]" Under O.C.G.A. § 43-34-22, the unlicensed practice of medicine is illegal.

In determining whether a Hospital actions constitute the unlawful practice of medicine, Georgia courts have looked to whether the the actions "create, define, direct, limit, or interfere with the physician-patient relationship or the attendant obligations, duties, rights, or liabilities arising from such professional relationship." *Health Horizons, Inc. v. State Farm Mut. Auto. Ins. Co.*, 239 Ga. App. 440, 447 (1999) (finding that a hospital does not practice medicine when a physician assigns billing collection rights to the hospital).

Cobb Cty.-Kennestone Hosp. Auth. v. Prince, 242 Ga. 139, 145 (1978), also relied upon this distinction. That case dealt with a hospital policy that stated, "if a treatment, procedure, diagnostic test or other service is ordered for a patient of Kennestone Hospital, And that procedure, test or service is routinely offered by the Hospital, then the patient will receive that service within the confines of the Hospital complex." The plaintiffs, who were neurologists and neurosurgeons, argued the policy "restricts and controls their medical judgment and is, therefore, void." In assessing whether the policy constituted the unlicensed practice of medicine, the Supreme Court recognized the the "delicate balance" between the roles of hospitals and physicians. On one hand, only the physician may practice medicine. On the other, a hospital may "prescribe reasonable rules and regulations" that govern the care of patients. *Id.* at 144.

In assessing whether the policy intruded on the physicians' right to practice, the Supreme Court drew a distinction between medical functions and administrative functions. "[T]here is a distinction between the making of a diagnosis, which we recognize as a medical function, and the selection of equipment to be used in deriving information for submission to the physician in order that he be able to make his diagnosis, which is an administrative function." *Id.* at 145. The Court held that, because the policy only required the "use of the hospital's facilities," and did not "curtail [the plaintiff's] medical judgment," the policy was administrative in nature and was not void. *Id.*

Although these prior decisions upheld the policies at issue, each did so only because the policies did not control a physician's medical decisions or interfere with the physician-patient relationship.

The unanswered question is whether a hospital can enact a blanket policy (for

example, forbidding mothers who have had more than two previous Cesarean sections from attempting a natural birth) which overrides the patient's wishes and her doctor's advice.

Cases where a provider obtained a court ordered Cesarean section

In *Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr., Inc.*, 66 F. Supp. 2d 1247, 1254 (N.D. Fla. 1999), the district court upheld a court-ordered Cesarean section for a mother who was in the process of attempting vaginal delivery after a Cesarean section, at her house, without a physician either participating or standing by. The woman's request to the hospital was not that she be allowed to deliver vaginally at the hospital but instead that the hospital provide an IV so that she could return home to deliver there. She did so in spite of the fact that "Every physician she contacted advised her that, because of the type of caesarean section she had undergone previously, vaginal delivery was not an acceptable option." Id. When the plaintiff initially refused to consent to a Cesarean section, "hospital officials set about securing additional opinions from board certified obstetricians [… who] separately concurred in the determination that a caesarean was medically necessary." While the hospital obtained those additional opinions, the plaintiff left the hospital surreptitiously.

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Georgia Laws re: Audio and Video Recording

Under O.C.G.A. § 16-11-62(1), it is unlawful for "[a]ny person in a clandestine manner intentionally to overhear, transmit, or record or attempt to overhear, transmit, or record the private conversation of another which shall originate in any private place." Under subsection (2), it is illegal for "any person, through the use of any device, without the consent of all persons observed, to observe, photograph, or record the activities of another which occur in any private place and out of public view . . . ."

O.C.G.A. § 16-11-66 (a) creates an exception to this rule and states that "[n]othing in Code Section 16-11-62 shall prohibit a person from intercepting a wire, oral, or electronic communication where such person is a party to the communication or one of the parties to the communication has given prior consent to such interception."

O.C.G.A. § 16-11-67 states that "[n]o evidence obtained in a manner which violates any of the provisions of this part shall be admissible in any court of this state except to prove violations of this part."

The exception created by O.C.G.A. § 16-11-66(a) applies to audio recordings only. *See State v. Cohen*, 302 Ga. 616, 627 (2017) (holding that O.C.G.A. § 16-11-66(a) did not apply to video recordings covertly captured by a spy camera in a bedroom, even though one party consented to the recording). *See also Sims v. State*, 297 Ga. 401, 401 n.2 (2015) (recognizing distinction between audible communication in recording that is subject to one-party-consent rule and video recording that is not).

The take-away points are: First, it may not be legal to record your hospital birth via video without consent of all parties involved because, under O.C.G.A. § 16-11-62, a hospital room *may* be considered a "private place and out of public view."[1] Second, you likely *can* covertly record your birth via audio so long as you (or another person) remain in the room with the recording device at all times. For example, if you leave your phone in a room, and exit the room, and record someone else's conversation, then you will have committed a felony. BE CAREFUL. Consult with an attorney before you record against hospital policy.

Family Separation

See the attached case *Holderman v. Walker*. I have no affiliation with this case, and include it because it provides a cogent summary of the constitutional law concerning the separation of a mother and infant.

1 There is room for debate here. The Court of Appeals recently held that a "private place" is defined as "a place where there is a reasonable expectation of privacy." O.C.G.A. § 16-11-60 (3). *See Weintraub v. State*, 352 Ga. App. 880, 889 (2019) for further discussion.

West's Code of Georgia Annotated
Title 31. Health
Chapter 9. Consent for Surgical or Medical Treatment (Refs & Annos)

Ga. Code Ann., § 31-9-2

§ 31-9-2. Persons who may consent to surgical or medical treatment

Effective: June 3, 2010
Currentness

(a) In addition to such other persons as may be authorized and empowered, any one of the following persons is authorized and empowered to consent, either orally or otherwise, to any surgical or medical treatment or procedures not prohibited by law which may be suggested, recommended, prescribed, or directed by a duly licensed physician:

(1) Any adult, for himself or herself, whether by living will, advance directive for health care, or otherwise;

(1.1) Any person authorized to give such consent for the adult under an advance directive for health care or durable power of attorney for health care under Chapter 32 of this title;

(2) In the absence or unavailability of a person authorized pursuant to paragraph (1.1) of this subsection, any married person for his or her spouse;

(3) In the absence or unavailability of a living spouse, any parent, whether an adult or a minor, for his or her minor child;

(4) Any person temporarily standing in loco parentis, whether formally serving or not, for the minor under his or her care; and any guardian, for his or her ward;

(5) Any female, regardless of age or marital status, for herself when given in connection with pregnancy, or the prevention thereof, or childbirth;

(6) Upon the inability of any adult to consent for himself or herself and in the absence of any person to consent under paragraphs (1.1) through (5) of this subsection, the following persons in the following order of priority:

(A) Any adult child for his or her parents;

(B) Any parent for his or her adult child;

(C) Any adult for his or her brother or sister;

(D) Any grandparent for his or her grandchild;

(E) Any adult grandchild for his or her grandparent; or

(F) Any adult niece, nephew, aunt, or uncle of the patient who is related to the patient in the first degree; or

(7) Upon the inability of any adult to consent for himself or herself and in the absence of any person to consent under paragraphs (1.1) through (6) of this subsection, an adult friend of the patient. For purposes of this paragraph, "adult friend" means an adult who has exhibited special care and concern for the patient, who is generally familiar with the patient's health care views and desires, and who is willing and able to become involved in the patient's health care decisions and to act in the patient's best interest. The adult friend shall sign and date an acknowledgment form provided by the hospital or other health care facility in which the patient is located for placement in the patient's records certifying that he or she meets such criteria.

(a.1) In the absence, after reasonable inquiry, of any person authorized in subsection (a) of this Code section to consent for the patient, a hospital or other health care facility or any interested person may initiate proceedings for expedited judicial intervention to appoint a temporary medical consent guardian pursuant to Code Section 29-4-18.

(b) Any person authorized and empowered to consent under subsection (a) of this Code section shall, after being informed of the provisions of this Code section, act in good faith to consent to surgical or medical treatment or procedures which the patient would have wanted had the patient understood the circumstances under which such treatment or procedures are provided. The person who consents on behalf of the patient in accordance with subsection (a) of this Code section shall have the right to visit the patient in accordance with the hospital or health care facility's visitation policy.

(c) For purposes of this Code section, the term "inability of any adult to consent for himself or herself" means a determination in the medical record by a licensed physician after the physician has personally examined the adult that the adult "lacks sufficient understanding or capacity to make significant responsible decisions" regarding his or her medical treatment or the ability to communicate by any means such decisions.

(d)(1) No hospital or other health care facility, health care provider, or other person or entity shall be subject to civil or criminal liability or discipline for unprofessional conduct solely for relying in good faith on any direction or decision by any person reasonably believed to be authorized and empowered to consent under subsection (a) of this Code section even if death or injury to the patient ensues. Each hospital or other health care facility, health care provider, and any other person or entity who acts in good faith reliance on any such direction or decision shall be protected and released to the same extent as though such person had interacted directly with the patient as a fully competent person.

(2) No person authorized and empowered to consent under subsection (a) of this Code section who, in good faith, acts with due care for the benefit of the patient, or who fails to act, shall be subject to civil or criminal liability for such action or inaction.

Credits

Laws 1971, p. 438, § 1; Laws 1972, p. 688, § 1; Laws 1975, p. 704, § 2; Laws 1991, p. 335, § 1; Laws 2001, p. 4, § 31; Laws 2007, Act 48, § 12, eff. July 1, 2007; Laws 2010, Act 616, § 1, eff. June 3, 2010.

Formerly Code 1933, § 88-2904.

Notes of Decisions (8)

Ga. Code Ann., § 31-9-2, GA ST § 31-9-2
The statutes and Constitution are current through Laws 2020, Act 329. Some statute sections may be more current, see credits for details. The statutes are subject to changes by the Georgia Code Commission.

End of Document

West's Code of Georgia Annotated
Title 31. Health
Chapter 9. Consent for Surgical or Medical Treatment (Refs & Annos)

Ga. Code Ann., § 31-9-7

§ 31-9-7. Right of person over 18 to refuse treatment as to his own person not abridged

Currentness

Nothing contained in this chapter shall be construed to abridge any right of a person 18 years of age or over to refuse to consent to medical and surgical treatment as to his own person.

Credits
Laws 1971, p. 438, § 1.

Formerly Code 1933, § 88-2907.

Notes of Decisions (5)

Ga. Code Ann., § 31-9-7, GA ST § 31-9-7
The statutes and Constitution are current through Laws 2020, Act 329. Some statute sections may be more current, see credits for details. The statutes are subject to changes by the Georgia Code Commission.

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937 F.Supp. 1169
United States District Court, D. Maryland.

Ariel J. BANKERT, an Infant by her Mother and Next Friend Kimberly BANKERT and Kimberly Bankert, Individually, Plaintiffs,
v.
UNITED STATES of America, Defendant.

Civil Action No. AW–94–2277.
|
Aug. 27, 1996.

Synopsis

Mother brought action on her own behalf as well on behalf of her infant daughter under Federal Tort Claims Act (FTCA), asserting negligence on part of medical personnel at Air Force hospital during labor and delivery of child. The District Court, Williams, J., applied Maryland law and held that: (1) evidence established violation of standard of care in failing to advise mother of risk of pitocin augmentation and in refusing her request for repeat cesarean section after she initially chose trial of labor delivery; (2) evidence established violation of standards of care as to child in failing to expedite delivery after problems were discovered; (3) medical personnel violated mother's right to informed consent by failing to inform her of risks of pitocin augmentation and by refusing to allow her to deliver by cesarean section; (4) evidence established mother's entitlement to $200,000 in noneconomic damages and child's entitlement to statutory cap of $350,000 in noneconomic damages; and (5) evidence justified award of $43,000 in economic damages for child for future supplemental therapeutic services over five years.

Ordered accordingly.

Attorneys and Law Firms

***1172** Kathleen Howard Meredith, Baltimore, MD, for plaintiffs.

Lynne A. Battaglia, United States Attorney, and James G. Warwick, Assistant United States Attorney, Baltimore, MD, for defendant.

OPINION AND ORDER

WILLIAMS, District Judge.

This is an action filed by the Plaintiffs, the infant Ariel Bankert by her Mother and Next Friend Kimberly Bankert, and Kimberly Bankert, individually, pursuant to the Federal Tort Claims Act, 28 U.S.C. § 1346(b) and §§ 2671–2680. Jurisdiction is invoked under 28 U.S.C. § 1346(b). Venue is proper in the United States District Court for the District of Maryland under 28 U.S.C. § 1402(b), as both Plaintiffs reside within the judicial district of Maryland and the acts and omissions complained of occurred within the judicial district of Maryland. Plaintiffs satisfied the administrative prerequisites before filing the action and the matter proceeded to trial before this member of the Court.

I. FINDINGS OF FACT

Based on the evidence received at the six (6) day non-jury trial held on July 2, 3, 8, 9, 10, and 11, 1996, the Court finds that the following facts have been established:

1. In June 1991, Kimberly Bankert was seen at Malcolm Grow Medical Center, a hospital and clinic complex run by the United States Air Force and located on Andrews Air Force Base. Kimberly Bankert was at that time married to and a dependent of Dennis Bankert, a Sergeant on active duty for the United States Air Force. A pregnancy test performed at that time confirmed that Kimberly Bankert was pregnant with her third child.

2. Kimberly Bankert had given birth to two previous children *via* cesarean section. The first section was performed on an emergency basis for fetal distress in 1987 while the second was an elective repeat cesarean section in June of 1988. The cesarean section for fetal distress in connection with Kimberly Bankert's first delivery was a bad and traumatic experience for both Kimberly and Dennis Bankert.

***1173** 3. When Mrs. Bankert became pregnant in 1991, she was under the care of Dr. Carol Rupe of the Family Practice Service at Malcolm Grow. Mrs. Bankert felt comfortable with Dr. Rupe and wished Dr. Rupe to follow her in her pregnancy.

4. In the 1960's and 1970's, any woman who delivered a baby by cesarean section was told she would have to have a cesarean section in connection with any subsequent pregnancy; in other words, the rule was "once a cesarean section, always a cesarean section."

5. Beginning in the 1980's, however, research indicated that many women who had previous cesarean sections could achieve successful vaginal deliveries if allowed a trial of labor. A successful vaginal delivery after a previous cesarean section is called a "VBAC" for vaginal birth after cesarean section.

6. There are certain risks associated with attempts at vaginal birth after cesarean section.

7. The most frequently occurring risk is the risk of failure.

8. The most serious risk of an attempt at vaginal birth after cesarean section is the risk of uterine rupture and its consequences. Uterine rupture is a risk of VBAC because once the uterine wall has been weakened by a previous surgical incision, there is an increased risk that the uterine wall will rupture under the stress of labor contractions.

9. Uterine rupture is an emergency situation of the gravest nature that can result in fetal brain damage, maternal hysterectomy and maternal and/or fetal death. Because of the catastrophic nature of the risks associated with uterine rupture, and despite the fact that the risk of uterine rupture is relatively small, the medical profession recognizes two equally acceptable approaches to the management of a patient with a history of prior cesarean section delivery: the first is to deliver the patient by repeat cesarean section and the second is to allow a trial of labor.

10. The doctrine of informed consent imposes on a physician, before he/she subjects his/her patient to medical treatment, the duty to explain the procedure to the patient and to warn her of any material risks or dangers inherent in or collateral to the proposed therapy, so as to enable the patient to make an intelligent and informed choice about whether to follow her physician's recommendation or to select some other medically acceptable treatment alternative.

11. Informed consent is defined as **"the willing and uncoerced acceptance"** of a medical intervention by a patient after adequate disclosure by the physician of the nature of the intervention, its risks and benefits, as well as of alternatives with their risks and benefits.

12. Where there are two or more medically acceptable treatment approaches to a particular medical problem, the informed consent doctrine, medical ethics, and the standard of care all provide that the competent patient has the absolute right to select from among these treatment options after being informed of the relative risks and benefits of each approach.

13. The informed consent doctrine holds that a physician has a legal, ethical and moral duty to respect patient autonomy and to provide only authorized medical treatment. Under the informed consent doctrine, a physician has an obligation to inform his/her patient of the potential risks of all medically acceptable treatment alternatives and the additional obligation to allow his/her patient to make a decision as to which of the medically acceptable treatment alternatives she is going to pursue.

14. The corollary to this rule is that it is unethical and below the applicable standard of care for a physician to pursue a treatment alternative other than the one to which his patient has given consent. Unless a patient consents to a treatment approach recommended by her physician, the physician may not proceed with that approach even if the physician personally believes his/her recommended approach to be in his patient's best interests.

15. A competent patient's right to select from among medically acceptable treatment alternatives also encompasses the right to change one's mind about the treatment ***1174** approach selected. A competent patient who has had two prior cesarean sections has the right to consent or withhold consent to a trial of labor. There is nothing about pregnancy or the onset of the labor process which automatically renders a woman incapable of rational thought or unable to participate in competent decision making.

16. Dr. Rupe advised Kimberly Bankert that as a Family Practice physician, she was not credentialed to perform cesarean section deliveries and could follow Kimberly only if she agreed to a trial of labor. Mrs. Bankert expressed to Dr. Rupe an interest in attempting a vaginal delivery of her third child. Dr. Rupe then referred Mrs. Bankert to the Obstetrics Department for a consultation.

17. In 1991, unbeknownst to Kimberly Bankert, the Obstetrics and Gynecology Department at Malcolm Grow Hospital had in effect a so-called "unanimous policy regarding trial of labor patients" which was repugnant to accepted principles of informed consent. The policy was that trial of labor candidates would be counseled regarding their options in terms of mode of delivery, the relative risks, benefits, advantages, and disadvantages of each. The

patients would be permitted to select from the two medically acceptable modes of delivery and their choice in this regard would be honored. The patients would be free to change their minds about the mode of delivery selected up until the point they entered labor. Once a patient who had elected to attempt a trial of labor began the labor process, however, the unwritten, unanimous policy provided that "the patient would be required to labor **no matter what** and cesarean section would be performed by the doctor only if he in his sole judgment determined that there was medical or obstetrical indication." [1]

18. On June 27, 1991, Kimberly Bankert saw Dr. Ronette Cyka of the Department of Obstetrics and Gynecology. Dr. Cyka advised that many women who have undergone past cesarean sections are able to deliver vaginally.

19. Dr. Cyka further advised Kimberly Bankert that many women change their minds about the trial of labor option once they enter labor **because of pain.** Dr. Cyka advised Kimberly Bankert that once she entered labor, Kimberly would not be permitted to change her mind **for reasons of pain.** Dr. Cyka did not advise Kimberly Bankert of the unwritten, unanimous policy adopted by the Malcolm Grow Department of Obstetrics and Gynecology during the pertinent time frame which prohibited VBAC patients from withdrawing consent to the trial of labor **under all circumstances** once labor began, and which further provided that once labor began, the decision to perform cesarean section would be up to the obstetrician and the obstetrician alone.

20. After consultation with Dr. Cyka, Kimberly Bankert opted to proceed with a trial of labor (VBAC, or vaginal birth after cesarean section).

21. Kimberly Bankert's pregnancy was healthy and uncomplicated as she remained under the care of the Family Practice physician, Dr. Carol Rupe.

22. On January 22, 1992, Mrs. Bankert presented to the Labor and Delivery Suite at Malcolm Grow Medical Center at approximately 2:15 a.m.—3:00 a.m. Her membranes had ruptured around 1:30 a.m. and she was experiencing contractions. Mrs. Bankert was accompanied by her husband, Dennis Bankert. After being admitted, Mrs. Bankert reaffirmed her desire to undergo a trial of labor by executing a patient's Informed Consent to proceed toward vaginal delivery.

23. On duty with the Family Practice Service was Mrs. Bankert's physician, Dr. Rupe and Dr. Kerr, a third year resident, who looked in on and covered for Dr. Rupe between approximately noon and 5:00 p.m. when Dr. Rupe assumed her duties at the acute care clinic.

24. Dr. James Nelson was the obstetrician covering the labor and delivery floor on January 22, 1992. His role in caring for Family Practice patients admitted to the labor ***1175** and delivery floor was to serve as a consultant to the Family Practice physicians, to be available should any high risk issues arise, and to perform cesarean section delivery should the need arise.

25. When Dr. Nelson came on duty at 7:00 a.m. on January 22, 1992, he was advised that Mrs. Bankert had been admitted to the Family Practice Service for a trial of labor after two prior cesarean sections. By virtue of Kimberly Bankert's history of two prior cesarean sections, Dr. Nelson concluded that she was at that point an intermediate risk patient.

26. Dr. Nelson did not examine or evaluate Kimberly Bankert at or around the time he received a report on her.

27. Although Kimberly Bankert labored from 1:30 a.m. to approximately 11:00 a.m., she failed to make significant progress toward delivery. Sometime after 11:00 a.m., the Family Practice Physicians attending Kimberly Bankert consulted with Dr. Nelson about the patient's failure to progress in labor. Between the hours of 1:00 p.m. and 5:00 p.m. Mrs. Bankert was given intra-partum interventions consisting of fluids, position changes and oxygen.

28. During that time, Dr. Nelson authorized the administration of a medication known as pitocin, a drug designed to bring on active labor, and to enhance the strength, duration and frequency of the uterine contractions of labor.

29. Because the administration of pitocin to a patient attempting vaginal birth after cesarean section elevates the risk of uterine rupture, hospital protocol required the Family Practice Physician to consult with and obtain approval from Dr. Nelson before administering the medication. Dr. Nelson did not personally examine or evaluate Kimberly Bankert before authorizing the use of pitocin.

30. The use of pitocin in a laboring VBAC patient increases the risk of uterine rupture and also creates the risk of fetal distress.

31. The Court finds that it was the policy, practice and procedure at Malcolm Grow Hospital as well as standard care for the attending physician to explain the risks and benefits of pitocin in order to obtain the patient's informed consent for use of the medication.

32. Prior to administering the pitocin, Malcolm Grow personnel did not advise Kimberly Bankert or her husband of the risks of this medication and, in particular, did not advise that use of the medication would further increase the risk of uterine rupture. [2]

33. The use of pitocin brought on strong and active labor contractions which significantly contributed to and more probably caused Kimberly Bankert's uterus to rupture.

34. Beginning at about noon on January 22, 1992, Malcolm Grow personnel began to express concerns to each other and to Kimberly and Dennis Bankert about the welfare of the unborn baby.

35. At 1:45 p.m., for example, both the long term and short term variability on the fetal heart monitor were described as absent and a nursing note described "a deep variable deceleration with a questionable late component."

36. At 2:35 p.m., Dr. Kerr wrote a note which stated: "subtle decelerations noted starting at 12:40 p.m. which progressed to mild and then to moderate variable decelerations but which resolved with changes in position, oxygen and increased fluids. Some decrease in beat to beat variability also noted. Now with occasional mild to moderate variable decelerations." Dr. Kerr's assessment was "slow progress, possible early evidence of fetal distress."

37. The term "fetal distress" refers to a precarious fetal condition that, allowed to persist, may lead to permanent damage or perinatal death. By definition, fetal distress is an emergency situation. The appropriate and required clinical response to sustained true fetal distress is prompt and immediate ***1176** delivery of the infant, if necessary, by emergency or stat cesarean section.

38. There can be abnormalities in fetal heart rate apparent on a fetal heart tracing which, though not clearly diagnostic of fetal distress, raise concerns about fetal well being. These abnormalities may or may not progress to true fetal distress. The usual clinical response to these early abnormalities is to give the mother oxygen, to increase her intravenous fluids, and to change her position.

39. The interventions employed by staff between noon and 3:00 p.m., *i.e.* the positional changes, the oxygen, the increase in IV fluids, were not new to Kimberly Bankert and her husband, Dennis Bankert. They had seen them used unsuccessfully in connection with Kimberly's first labor which had ultimately resulted in the emergency cesarean section for fetal distress.

40. By 3:00 p.m., Kimberly had been in labor over twelve hours and was still only four centimeters dilated. She and her husband believed that any vaginal delivery was many hours off. They were worried about their baby because of the comments and actions of hospital personnel and because of their own understanding as to the significance of the clinical interventions designed to resolve the early fetal heart rate abnormalities. They began to doubt whether Kimberly Bankert could successfully give birth by labor. If unsuccessful, they feared labor would have to be terminated by a stat cesarean section for fetal distress or other emergency, something they had been through before and wished to avoid.

41. Because of these concerns, they told their labor and delivery nurse, Penny Davis, that they wished to see the doctor in order to request a cesarean section. It was clear to Penny Davis from the tone and content of Kimberly Bankert's remarks that she wanted to terminate the trial of labor and to have a cesarean section.

42. At the time Kimberly and Dennis Bankert made their decision to withdraw consent to the trial of labor and to pursue cesarean section, there was nothing about this patient that deprived her of the capacity to consent or withhold consent to the two treatment alternatives for her delivery.

43. At approximately 3:30 p.m., Dr. Kerr responded to the patient's room where Mr. and Mrs. Bankert reiterated their request for cesarean section. Though Dr. Kerr attempted to reassure Mr. and Mrs. Bankert, they were adamant in their request for cesarean section because of their concern for their unborn infant, the slow progress Kimberly had made in labor, their awareness that the trial of labor might not be successful, and their desire to avoid an emergency surgical delivery. Dennis Bankert specifically challenged Dr. Kerr when she advised that the baby was fine and that there was no medical reason at that time for a cesarean section.

44. Ordinarily Dr. Kerr would have dealt with a request by a laboring VBAC patient for cesarean section on her own and without involving the attending obstetrician. She would ordinarily summon the obstetrician only where she felt there was a medical or obstetrical indication for cesarean section or where the patient was being particularly insistent about her request.

45. Dr. Kerr did not see an obstetrical indication for cesarean section when she summoned Dr. Nelson to deal with the Bankerts' request for cesarean section. Dr. Kerr approached Dr. Nelson and advised him that Kimberly Bankert and her husband had requested a cesarean section delivery. Dr. Kerr explained that Mrs. Bankert and her husband had been expressing concerns about the welfare of their unborn infant and wished to have a cesarean section.

46. Dr. Nelson responded to the patient's room at approximately 3:45 p.m. He performed a pelvic exam and reviewed the fetal heart rate tracing in an effort to identify evidence of fetal distress.

47. Dr. Nelson's review and interpretation of the tracings did not reveal true fetal distress as that term is medically defined. Dr. Nelson's pelvic exam revealed that Kimberly Bankert was only 5–6 centimeters dilated ***1177** with the baby's head at the 0 to –1 station. [3]

48. Dennis Bankert reiterated to Dr. Nelson the request for cesarean section. Although Dr. Nelson could not recall how many times Dennis Bankert requested cesarean section he does recall that he was clearly aware that Dennis and Kimberly wanted a cesarean section.

49. Dr. Nelson responded by stating that the baby was doing fine, labor was progressing, and there was in his judgment no "medical indication" for cesarean section at that time. Dr. Nelson offered medication to help alleviate Mrs. Bankert's pain and conveyed to them that in his best opinion, they should proceed with the trial of labor.

50. Nurse Penny Davis was sent from the room to obtain the pain medication which Dr. Nelson had ordered. Dr. Nelson remained in the room with Dennis and Kimberly Bankert.

51. Dr. Nelson was a Major in the United States Air Force, as opposed to Kimberly Bankert's husband, Dennis Bankert, who held the rank of Sergeant.

52. As a career military man, Dennis Bankert was respectful for the chain of military authority, and therefore was somewhat reluctant to openly question or challenge the directions of a senior officer.

53. Despite the fact that Dr. Nelson outranked him, Dennis Bankert who along with Mrs. Bankert was very worried about their baby and, possibly, angry and upset, specifically challenged Dr. Nelson's evaluation of the situation and in Dr. Nelson's words became "a little belligerent."

54. Although Dr. Nelson's next response is highly disputed, the Court accepts the testimony of Dennis and Kimberly Bankert that Dr. Nelson raised his voice, shook his finger at Dennis Bankert, and said words to the effect of: "First of all, I am the doctor, you're not, and I'm the one who decides whether or not she gets a c-section, not you! Secondly, we have a pact with her." [4]

55. At that point, Dennis and Kimberly Bankert remained silent or in the words of Dr. Nelson, Dennis Bankert "backed off", and did not press the issue anymore.

56. Penny Davis re-entered the room after obtaining the pain medication and proceeded to administer the pain medication in accordance with Dr. Nelson's previous order.

57. Sometime around 4:00 p.m., Kimberly Bankert called her friend, Jan Rule, advising Mrs. Rule that she (Kimberly) was mad. Kimberly Bankert also advised Mrs. Rule that Dr. Nelson had refused her request for cesarean section, that "he wouldn't even consider a c-section", that he had yelled at her and her husband and told them that they "would not get a cesarean section, because he was the doctor."

58. Dr. Rupe entered the labor room sometime after 5:10 p.m., and Kimberly and Dennis Bankert asked why they had been denied their request for cesarean section. Kimberly Bankert also complained to Dr. Rupe, that Dr. Nelson had been rude, curt and abrupt in denying her and her husband their requested cesarean section. Dr. Rupe indicated that "her hands were tied" and the decision was Dr. Nelson's alone.

59. At approximately 6:30 p.m., Kimberly experienced a tearing sensation in her abdomen that "felt like the baby was coming out through the side." Labor and delivery nurse Penny Davis, believing the patient's complaint of increased pain to be a sign that she might be fully dilated, left the room,

contacted Dr. Rupe and received permission from Dr. Rupe to perform a vaginal examination.

60. Upon return to the patient's room at 6:32 p.m., Penny Davis performed her vaginal examination, noted a bloody discharge from Mrs. Bankert's vagina, and assessed the patient at 9 centimeters of dilation. At about the same time, she noted that the unborn baby had developed a severe bradycardia or ***1178** slowing of the heart rate and that the heart rate did not increase when she scratched the fetal head.

61. Nurse Penny Davis summoned Dr. Rupe to bedside. Dr. Rupe arrived at bedside within seconds of the onset of the fetal bradycardia. Dr. Rupe performed a vaginal examination and erroneously assessed the patient at 10 centimeters of dilation, and requested, the staff to set up for a vaginal delivery.

62. Dr. Rupe recognized immediately upon arrival at bedside that she had an emergency situation on her hands, that the baby was in fetal distress, and that she was in need of assistance. She wanted Dr. Nelson notified and summoned there as soon as possible.

63. Dr. Rupe testified that she immediately issued an order to Nurse Penny Davis to stat page Dr. Nelson.[5] Penny Davis testified that she does not recall an order for a stat page. The Court finds that Dr. Rupe never issued an order for a stat or emergency page, but rather requested only that Dr. Nelson be called or paged.[6]

64. Dr. Nelson arrived at bedside at approximately thirteen to sixteen minutes after the onset of the bradycardia and approximately thirteen to fifteen minutes after he was first paged.

65. Upon arriving in the labor room, Dr. Nelson quickly assessed the situation, determined that the cervix was not fully dilated and recognized that an emergency cesarean section was required. Dr. Nelson then ordered preparations for an emergency cesarean section delivery.

66. An emergency cesarean section was performed under general anesthesia and Ariel Bankert was delivered at 6:59 p.m.

67. Upon incising Kimberly Bankert's abdomen, Dr. Nelson identified a large amount of blood, and also observed that the baby's head was protruding through a rupture of the uterine wall into the abdomen. Dr. Nelson turned the baby, Ariel Bankert, over to the Family Practice Physicians who were assisting in the delivery.

68. At delivery, Ariel was floppy and anoxic with APGAR scores of 1 at one minute, and 1 at five minutes.[7] The only sign of life in Ariel Bankert at one and five minutes of age was a depressed heart rate.

69. At birth, Ariel's diagnosis was anoxic episode secondary to uterine rupture and maternal hemorrhage. Suffering from asphyxia and severe acidosis, Ariel required emergency neonatal resuscitation. Because of the lack of contemporaneous records having been created or maintained, however, the Court is unable to precisely determine the efficacy of the neonatal resuscitation effort.[8]

70. Several unsuccessful attempts at intubation prolonged the period of less than optimal oxygenation to the infant.

71. A chest x-ray was taken of Ariel Bankert at approximately 8:30 p.m. when she was one and one half hours of age. The chest x-ray was misinterpreted as normal by ***1179** the Family Practice Physicians attending Ariel. The chest x-ray in fact showed a right sided tension pneumothorax which is a collection of air between the chest wall and the lung. The chest x-ray further demonstrated that the pneumothorax was sufficiently large to displace the heart and other structures in the chest and to prevent the right lung from properly expanding.[9]

72. At approximately 9:30 p.m., a neonatal transport team arrived from Bethesda Naval Hospital. The previously taken chest films were again reviewed and it was at this point that the right-sided pneumothorax was diagnosed. The pneumothorax was treated by the insertion of a chest tube which released the collection of air in the chest and allowed the lung to fully and properly expand.

73. The Court finds that the delay in diagnosing and treating the pneumothorax further interfered with optimal oxygenation to Ariel and further compromised and exacerbated her condition, though it is impossible to determine what percentage of her current injury would have been avoided had the pneumothorax been promptly diagnosed and treated.

74. During the time that Ariel Bankert was being resuscitated, Dr. Nelson was performing surgery on Kimberly Bankert. Because of the size and location of the uterine rupture, (along

the side wall) Dr. Nelson performed a hysterectomy. During the surgery, Dr. Nelson removed Kimberly Bankert's uterus, as well as her left ovary and fallopian tube. There is no suggestion whatsoever that Dr. Nelson's decision to perform a hysterectomy at this point was anything less than appropriate.

75. Because of the large volume of blood loss, Kimberly Bankert was transfused with three units of blood.

76. Ariel has experienced developmental delays after birth. The Court finds that Ariel suffers from a form of cerebral palsy. Consistent with this diagnosis, Ariel suffers from right-sided hemiplegia and from a developmental language delay. The Court finds that Ariel's cerebral palsy was primarily caused by a deprivation of oxygen during the period between the rupture of Mrs. Bankert's uterus and the delivery of the child by Dr. Nelson.

77. Ariel Bankert is now four years of age. She is not as agile as other children, has some difficulty with her balance and with going up and down steps. She has difficulty with fine motor skills (particularly on the right side), and has delay in the development of her language skills. Her ability to understand is better than her ability to communicate. Ariel's intelligence is in the low range of average. Ariel is also "at risk" for the development of learning disabilities and/or other problems (e.g.—executive functioning).

78. The physical and neurological impairment described above were proximately related to the global anoxic/hypoxic brain injuries.

79. Ariel has undergone several neuropsychological and developmental evaluations and other testing to determine the appropriate therapeutic program to address her difficulties. She has received physical therapy, educational and developmental services with the Prince George's County School System since April 1993, in an effort to improve her language, cognitive, motor, and adaptive skills. She has also attended sessions at the Wately Special Center, the P.G. Community College, and the University of Maryland clinics for their intervention services to meet her needs.

80. The Court finds that the various intervention services employed over the years have resulted in some improvement of Ariel's motor, cognitive, and language deficiencies, however, more services at this time are required in order to maximize Ariel's potential, and to assist her in overcoming her difficulties.

81. At the request of Kimberly and Dennis Bankert (the parents of Ariel), the educational services provided by the Prince George's County School System have been ***1180** terminated. The parents prefer to "home school" Ariel as they do with their other three children.[10] Ariel does, however, attend the school (Wheatley Special Center) two days per week for speech and motor skills.

82. While Ariel is "at risk" for the development of a learning disability or problems with executive functioning, there is no present evidence of such disabilities.

83. It is undisputed that had Dr. Nelson honored Kimberly and Dennis Bankert's request for cesarean section when asked to do so at approximately 3:45 p.m. on January 22, 1992, Kimberly Bankert never would have experienced a uterine rupture, and would never have been required to undergo an emergency hysterectomy, and would not have lost her ability to bear children.

84. As testified to by several experts, had Dr. Nelson honored Kimberly and Dennis Bankert's request for cesarean section when asked to do so at approximately 3:45 p.m. on January 22, 1992, Ariel Bankert would have been born without incident, and without the brain damage and other disabilities from which she suffers today.

II. *CONCLUSIONS OF LAW*

A. *Generally*

1. Plaintiffs bring this action pursuant to the Federal Tort Claims Act, hereinafter FTCA, 28 U.S.C. § 2671, *et seq.* Under Section 2674 of the FTCA, the United States is liable to the same extent as an individual in similar circumstances, except that the United States is not liable for prejudgment interest or punitive damages. The Court is to apply the substantive law of the place where the allegedly negligent or wrongful act or omission occurred. *See* 28 U.S.C. §§ 1346(b) and 2674. As such, the controlling law in this case is the law of Maryland. State law controls both as to liability and damages. *United States v. Muniz,* 374 U.S. 150, 153, 83 S.Ct. 1850, 1852–53, 10 L.Ed.2d 805 (1963); *United States v. Streidel,* 329 Md. 533, 535, 620 A.2d 905 (1933); *Burke v. United States,* 605 F.Supp. 981, 987 (D.Md.1985).

A physician has a duty under Maryland law to use that degree of care and skill which a reasonably competent physician,

acting in the same or similar circumstances, would have used. *Benson v. Mays,* 245 Md. 632, 227 A.2d 220 (1967); *Shilkret v. Annapolis Emerg. Hosp. Ass'n,* 276 Md. 187, 349 A.2d 245 (1975). Failure to use the requisite degree of skill amounts to negligence. Whether the Defendant's conduct complied with the applicable standard of care is a question of fact to be determined by a review of all the evidence (including expert testimony).

The United States is vicariously liable and responsible for the conduct of all of its agents, servants and employees under the Federal Tort Claims Act and the applicable common law. *Cox v. Prince George's County,* 296 Md. 162, 460 A.2d 1038 (1983). Finally, several negligent acts may combine together to proximately cause harm.

B. *Kimberly L. Bankert's Negligence Claim*

The Court believes that the defendant acting through its employees violated the applicable standards of care as to Kimberly L. Bankert. *First,* the Court finds that the defendant owed a duty, specifically, to advise Plaintiff, Kimberly L. Bankert, of the risks of pitocin augmentation prior to it having been administered in this case. Defendant argues that the infusion of pitocin to augment labor is an ordinary labor management step which does not require either an additional nor separate informed consent from the patient. The Court disagrees. There was testimony from several physicians including Dr. Nelson, the delivering obstetrician in this case, to the effect that the administration of pitocin elevates the risk of uterine rupture, and that it would have been standard hospital protocol at Malcolm Grow Hospital for the attending physicians to discuss ***1181** the risks of pitocin with the patient before administering it. Dr. Rupe, the attending physician, stated at trial that after reflecting on her deposition testimony, she was now certain that she discussed the risks and benefits of pitocin with Kimberly L. Bankert. The Court, however, has no reason to question Kimberly Bankert's testimony that no such discussion took place. The Court, therefore, concludes that defendant breached the applicable prevailing standard of care by failing to advise Kimberly Bankert of the risk of pitocin augmentation.

Second, the Court believes that the defendant breached its duty owed to Kimberly Bankert by refusing her request for a repeat cesarean section shortly after 3:00 p.m. Kimberly Bankert was rational and unequivocal in her request for a cesarean section. She had been in labor for 12–14 hours with relatively minimal progress, she and her husband had observed clinical intervention measures being employed by the hospital staff to induce labor, and she had become very concerned about her baby. Moreover, Mrs. Bankert no longer believed she could succeed with a vaginal delivery, and she very much wanted to avoid an emergency cesarean delivery which brought back unpleasant memories she had previously experienced with one of her other children. According to the Bankerts, Dr. Nelson refused their request and did so in a rude, loud and firm manner. It is undisputed that had Dr. Nelson honored Kimberly and Dennis Bankert's request for cesarean section when they asked for it, Kimberly Bankert never would have experienced a uterine rupture, and never would have been required to undergo an emergency cesarean and emergency hysterectomy. The Court concludes that the defendant owed a duty to reasonably accommodate the request of Kimberly Bankert for a cesarean section. The Court further concludes that defendant, by refusing the cesarean section, breached its duty, departed from the standard of care, and, thereby, proximately caused the uterine rupture to Kimberly Bankert.

C. *Ariel J. Bankert's Negligence Claim*

The Court also believes that the defendant acting through its employees violated the applicable standards of care as to Ariel J. Bankert.[11] *First,* the applicable standard of care required a delivery of Ariel as quickly as possible following the onset of bradycardia at 6:32 p.m. Dr. Rupe recognized that the situation entailed an emergency and needed the immediate assistance of Dr. Nelson. *Either* Dr. Rupe issued an order for a stat page which was ignored by staff (Nurse Penny Davis in particular), *or* as the Court found no stat page was ordered. At any rate it is a distinction here without real meaning. Dr. Nelson did not arrive in the room until approximately sixteen minutes after the onset of the fetal bradycardia. Once arriving at bedside, Dr. Nelson quickly set up for a surgical delivery whereupon Ariel was delivered at 6:59 p.m., approximately 27 minutes after the onset of the fetal bradycardia.

The standard of care required delivery of the infant as quickly as possible. Kimberly Bankert as a "VBAC" candidate was a high risk patient. Possible fetal distress was noted earlier, and labor had not progressed as well as expected. The failure to have issued a stat page at the onset of the fetal bradycardia represented a departure from the applicable standard of care. The American College of Obstetrics and Gynecology (ACOG) Guidelines requiring the delivery of a child within thirty (30) minutes from the time the decision is made to surgically intervene until the delivery of the infant is merely a guideline. It represents, in the Court's view, the maximum

period of elapse. Those guidelines cannot blindly address every situation of emergency cesarean delivery.

In the circumstances of this case (i.e. high risk (VBAC) patient, earlier note of possible fetal distress, patient having earlier requested a cesarean delivery following twelve (12) ***1182** hours of relatively slow progress at an attempted vaginal delivery, and Dr. Rupe (attending physician) having recognized that she had an emergency within seconds of the onset of the fetal bradycardia and needed immediate assistance) a stat page rather than a regular page to Dr. Nelson was mandatory. There was, in the Court's view, an unreasonable delay of several critical minutes in delivering Ariel Bankert, caused by the failure to have arranged for a stat page. The timing of her delivery, therefore, fell below the applicable standard of care.

The evidence further reflects that after Ariel's delivery, the staff failed to diagnose or treat Ariel's pneumothorax. It was not until the neonatal intensive care unit from Bethesda Naval Hospital arrived at Malcolm Grow Medical Center, that the presence of a right-sided pneumothorax was diagnosed. It was then immediately treated by inserting a chest tube into the infant which then enabled Ariel's lungs to expand so as to assist in her breathing. While it is impossible to determine what percentage of Ariel's injury was caused by the delayed diagnosis and treatment of the pneumothorax, the Court believes that such failure contributed to the injuries sustained, and also constituted a deviation from the applicable standard of care.

D. *Kimberly Bankert's Informed Consent Claim*

Maryland subscribes to the doctrine of informed consent. Under this rule, a physician, treating a mentally competent adult under non-emergency circumstances, cannot properly undertake therapy without the prior consent of his patient and cannot provide treatment to the patient except in accordance with the patient's authorization and consent. *Sard v. Hardy,* 281 Md. 432, 438–439, 379 A.2d 1014 (1977). "The fountain head of the doctrine of informed consent is the patient's right to exercise control over his own body, at least when undergoing elective surgery, by deciding for himself whether or not to submit to the particular therapy." *Sard,* 281 Md. at 439, 379 A.2d 1014.

This doctrine, then, "imposes on a physician, before he subjects his patient to medical treatment, the duty to explain the procedure to the patient and to warn him of any material risks or dangers inherent in or collateral to the therapy, so as to enable the patient to make an intelligent and informed choice about whether or not to undergo such treatment." *Id.* "Once the physician has ascertained the risks and alternatives, and has communicated this information to the patient, it is the patient's *exclusive right* to weigh these risks together with his individual subjective fears and hopes and to determine whether or not to place his body in the hands of the surgeon or physician" and whether or not to follow the physician's recommendation or some other treatment alternative. *Id.* at 443, 379 A.2d 1014 (citing *Collins v. Itoh,* 160 Mont. 461, 503 P.2d 36, 40 (1972)). "The law does not allow a physician to substitute his judgment for that of the patient in the matter of consent to treatment." *Sard,* 281 Md. at 440, 379 A.2d 1014.

Kimberly Bankert claims that defendant first violated her right to informed consent by failing to inform her of the risks of pitocin prior to its use. To sustain a cause of action on her informed consent claim, Mrs. Bankert must establish: (1) that the physician failed to warn her of a material risk inherent in or collateral to the proposed therapy; (2) that the undisclosed risk materialized and caused injury; and (3) that a reasonable person in her position would not have consented had there been a disclosure of the material risk. *See Zeller v. GBMC,* 67 Md.App. 75, 506 A.2d 646 (1986); *Lipscomb v. The Memorial Hospital,* 733 F.2d 332 (4th Cir.1984). *Sard* further held that the causality requirement is an "objective test: whether a reasonable person in the patient's position would have withheld consent to the surgery or therapy had all material risks been disclosed." *Sard,* 281 Md. at 450, 379 A.2d 1014. She must prevail on each element to satisfy this test.

In this case, the Court believes that Mrs. Bankert has sustained her burden. Mrs. Bankert has established by a preponderance of the evidence (1) that the risks of pitocin, including the increased risk of uterine rupture, were not disclosed to her; (2) that the undisclosed risk of uterine rupture materialized and caused injury; and (3) that a reasonable ***1183** person in her position and under the totality of circumstances she found herself in would likewise have declined the treatment had she been aware of the risks. In fact, it was not long after the administration of pitocin that Mr. and Mrs. Bankert specifically requested a cesarean section and wanted no further attempt at vaginal delivery. It is doubtful, in the Court's view, that a reasonable patient in Kimberly Bankert's position would necessarily have followed Dr. Nelson's advice to proceed with labor; particularly in light of the entire circumstances previously described.

The Court also cannot accept the argument that the administering of pitocin to Mrs. Bankert did not require a separate informed consent on the part of the patient. The defendant posits that the general consent form to vaginal delivery executed by Mrs. Bankert on January 22, 1992, covered the infusion of pitocin during her labor. The Court, however, believes that because the use of pitocin increased the risk of uterine rupture and also created the risk of fetal distress, the appropriate standard of care required a separate discussion of its risks and benefits prior to it administration. Moreover, there was ample and credible testimony that it was policy, practice and procedure at Malcolm Grow Hospital for the attending physician to explain the risks and benefits of pitocin administration if, during the course of labor, a decision was reached to use pitocin, to obtain the patient's informed consent for use of the medication. The failure of Dr. Rupe or other staff personnel to advise Kimberly of the risks of pitocin augmentation constituted a breach of hospital policy, a departure from the applicable standard of care, and a breach of the informed consent doctrine.

In addition, the Court is also convinced that the defendant continued the trial of labor without Kimberly Bankert's consent and contrary to her [and her husband's] request around 3:00–3:45 p.m. for a cesarean section. As stated previously, "the law does not allow a physician to substitute his judgment for that of the patient in the matter of consent to treatment." *Sard,* 281 Md. at 440, 379 A.2d 1014. Moreover, "a corollary to the [informed consent] doctrine is the patient's right, in general, to refuse treatment and to withdraw consent to treatment once begun." *Mack v. Mack,* 329 Md. 188, 210, 618 A.2d 744 (1993). It is undisputed that Kimberly and Dennis Bankert first requested cesarean section delivery from Penny Davis, the Labor and Delivery Nurse, then from Dr. Mary Beth Kerr Jackson, her attending Family Practice Physician, and ultimately the request for cesarean section was communicated directly to Dr. James Nelson, the attending obstetrician.

The defendant (Dr. Nelson in particular) asserts that there was no medical indication for a cesarean section at that time, that the Bankerts' request was based on misinformation, and that to have performed cesarean delivery on the misinformed request would have constituted fraud, malfeasance, and would have been unethical. Nevertheless, Dr. Nelson contends he would have performed the section had the Bankerts insisted rather than merely requested, the cesarean section. Finally, Dr. Nelson testified that from the Bankerts' subsequent silence, he assumed they had acquiesced in his decision that labor should proceed.

The Court disagrees. *First,* regardless of whether there was or was not misinformation, the Court finds that the request by the Bankerts was not based solely on the medical indications at that time; on the contrary, the Court finds that the request was undergirded by several factors and apprehensions clearly reasonable under the totality of the circumstances confronting them. Mrs. Bankert had been laboring for more than 12 hours with rather slow progress. The Bankerts wanted to avoid a repeat of their previous unpleasant experience with an emergency cesarean, and they began to feel that Kimberly Bankert would not succeed in vaginal delivery. Of course, they were also concerned about their baby. They observed the interventions (change in position, infusion of fluids, and use of oxygen) which had been employed by staff, and they heard comments and discussions by staff as to the slow progress of labor. For all of these reasons, they had reservations as to whether they should continue with labor.

***1184** *Secondly,* the situation in the bedroom was very tense and emotional. Dr. Nelson did not recall how many times Mr. Bankert requested a cesarean delivery, but he did testify that Dennis Bankert became a little belligerent, perhaps, upset and angry at the decision of Dr. Nelson not to perform the cesarean section. At some point, the conversation abruptly ended, and the Bankerts became silent. Dr. Nelson says that they "backed off." He believed and argues, therefore, that Mrs. Bankert never withdrew her consent to the trial of labor.

The Court disagrees. Backing off under these circumstances is hardly acquiescence. Dr. Nelson, in effect, blocked the direction in which they wanted to go. Immediately after Dr. Nelson left the room, Kimberly Bankert called her girlfriend, to complain that she was angry that Dr. Nelson had been rude, had hollered at them, and had refused their request for cesarean delivery. Shortly thereafter, both Mr. and Mrs. Bankert complained to Dr. Rupe. She indicated that it was out of her hands. Moreover, following the delivery and while recovering from the cesarean section and the hysterectomy, Kimberly Bankert advised Dr. Rupe that she did not want to talk with Dr. Nelson who would be entering the room to discuss what had occurred. These discussions and comments by the Bankerts following the encounter with Dr. Nelson at 3:30–3:45 p.m. were most significant and further convince the Court that Dr. Nelson refused their request for a cesarean delivery. Nor can the Court conclude that Dr. Nelson had a reasonable basis to believe that the Bankerts

had not withdrawn their consent for vaginal delivery. It also appears quite reasonable for Dennis Bankert to have exhibited some deference to Dr. Nelson, an officer and his superior in rank, which possibly explained why "they backed off." Furthermore, Dr. Nelson conceded that Dennis Bankert was "somewhat belligerent." The record is simply devoid of any reasonable basis to conclude that the Bankerts had acquiesced in Dr. Nelson's decision to continue labor. Mere silence, under these circumstances, did not amount to acceptance of the decision reached by Dr. Nelson.

In summary, the Bankerts made a personal decision as patients to withdraw their consent to the trial of labor and to request the alternative, medically acceptable, approach of cesarean delivery. Although Dr. Nelson exercised his medical judgment and determined that cesarean delivery was not medically indicated, he nevertheless denied Kimberly Bankert the right to withdraw her consent to a particular medical procedure, and he denied her the opportunity to exercise her personal autonomy to make decisions regarding her own body. The Court concludes that defendant violated Mrs. Bankert's right to informed consent.

E. *Damages*

Having determined that the United States is liable in this action for the tortious actions of its employees and agents, the Court next considers what damages are to be awarded. Maryland limits non-economic damages to $350,000 and requires the trier of fact to itemize economic damages. Md.Code Ann.Cts. and Jud.Proc. §§ 11–108 and 11–109. Both Ariel and Kimberly Bankert claim noneconomic damages as a result of the acts of the defendant in this case. A claim for economic damages in the amount of $2,289,979 has also been asserted on behalf of Ariel for future medical expenses, future loss of income, and other future educational and related expenses.

With reference to the noneconomic damage claim of Ariel, it is undisputed that she has been diagnosed as suffering from a form of cerebral palsy, accompanied by right sided hemiparesis. She also has difficulties with fine motor skills, language skills and has some problems with adaptive as well as cognitive skills. These difficulties along with the related injuries sustained through the combination of birth complications and neonatal circumstances were proximately caused by a breach of standard of care owed by the defendant, and are clearly recoverable as compensable non-economic damages. The Court believes that an award of $350,000.00 in non-economic damages to Ariel Bankert is appropriate.

Kimberly Bankert has also sustained damages because of the tortious conduct of ***1185** the defendant. She experienced the trauma of the rupture of her uterus and the resulting hysterectomy and loss of blood. In connection with the hysterectomy, the left ovary and fallopian tube was removed with a concomitant loss of her reproductive capacity. The defendant argues that no award should be made for loss of reproductive capacity inasmuch as there was testimony from witnesses who heard Kimberly Bankert state that she did not plan to have additional children after Ariel. The simple response to this argument is that Kimberly Bankert did not request a hysterectomy. Moreover, as a 31 year old female, she was more than able to have other children and could have changed her mind about having more children. She is now unable to change her mind, and has permanently lost child bearing years that she otherwise would possess. The Court, therefore, believes that an award of $200,000 in non-economic damages appropriately compensates Kimberly Bankert for her damages.

Lastly, the Court addresses the claim on behalf of Ariel Bankert for economic damages. This issue is far more complex and difficult inasmuch as Ariel is only four years old, and is not yet at school age. Further complicating the issue is the fact that Ariel has made significant improvements in her functional capabilities because of various early intervention services, yet she still requires further therapy, evaluations, monitoring and other services in order to accommodate her needs.

The essential dilemma before the Court is [to put it succinctly and in the words of Kimberly Bankert] that we "don't know what's going to happen to Ariel." The evidence in support of economic damages produced by Plaintiff at best indicated that Ariel is "at risk" for the development of a learning disability and/or problems with executive functioning. In *Davidson v. Miller,* 276 Md. 54, 62, 344 A.2d 422, 427–28 (1975), the Court of Appeals of Maryland, while addressing the burden of proof in medical malpractice cases, stated: "In Maryland, recovery of damages based on future consequences of an injury may be had only if such consequences are reasonably probable or reasonably certain. Such damages cannot be recovered if further consequences are 'mere possibilities.' Probability exists when there is more evidence in favor of a proposition than against it (a greater than 50% chance that a future consequence will occur). Mere possibility exists when the evidence is anything less." *See also Muenstermann v.*

United States, 787 F.Supp. 499, 522 (D.Md.1992); *Weimer v. Hetrick,* 309 Md. 536, 549–550, 525 A.2d 643, 650 (1987).

To award economic damages for future consequences to Ariel in this case requires proof that such projected damages will likely, reasonably and probably result from the acts of the defendant. With the possible exception as to the need for continuous and supplemental therapeutic services, the Court cannot find that plaintiffs have established to a reasonable degree of probability entitlement to the individualized life care plan for Ariel Bankert outlined by Dr. Sheryl Ranson. Dr. Ranson's conclusions (that it is unlikely that Ariel will be gainfully employed in the competitive labor market, will likely be in some kind of sheltered program or in a supported employment program, and will likely require respite long term care and supported living assistance) are no more than conjecture and sheer speculation. The assumptions and conclusions taken by Dr. Ranson are based upon a negative or "worst scenario." As Kimberly Bankert testified we "don't know what is going to happen to Ariel." The Court likewise is not in a position to predict. Fortunately, the evidence reflects continued improvement and some positive response through early interventional services.

Moreover, although plaintiffs have decided to home school Ariel, along with their other children, they are still entitled to supplementary intervention and treatment services with the public school system or at a placement approved by the school system. Presently, Ariel is enrolled in the Paul Hahn Clinic with the Prince George's County Community College. While Ariel is not receiving public school treatment services during the summer, it is possible that she may return for limited special educational services with the Prince George's County Public School System. ***1186** [12] Inasmuch as the Bankerts intend to home teach Ariel, and in light of the supplemental services through public education, as well as the various benefits available to Ariel as a dependent of Dennis J. Bankert, the Court cannot find a general basis to award economic damages for those services.

The Court does believe, however, and does find from a review of the medical records that to assure maximum development Ariel should receive therapy at least once or twice per week for a reasonable period of time. This therapy more likely than not, is in addition to what is publicly available, will have to be worked in around Ariel's "home schooling," and, more probably, will include services (including yearly evaluations) not covered by benefits possessed by Dennis Bankert.

The Court believes and finds that these additional therapeutic services are reasonably necessary at least once per week at a cost of $200 per week for the next five years. [13] A yearly evaluation and report at $200 per year is also reasonably necessary. Accordingly, the Court awards $43,000.00 in economic damages to Ariel for future supplemental therapeutic services over the next five years.

Finally, the Court simply cannot find, by a preponderance of the evidence, a causal connection between Ariel's alleged injuries and behavior difficulties. Neither can the Court conclude that plaintiff has proven by a reasonable probability that Ariel is entitled to any other future economic awards set forth under Dr. Ranson's life care plan. As stated before, Ariel may be "at risk," however, "at risk" is the very essence of "mere possibilities," which cannot be the basis of an award for economic damages.

SUMMARY

In light of the foregoing Findings and Conclusions, the Court concludes that the defendant, United States of America, in acting by and through its agents negligently, tortiously and proximately caused damage to Kimberly and Ariel Bankert. The Court finds that plaintiffs are entitled to the damages set forth herein. The total damage award is $593,000.00 which includes $350,000.00 to Ariel Bankert representing non-economic damages, $43,000.00 to Ariel Bankert representing future economic damages, and $200,000.00 to Kimberly Bankert representing non-economic damages.

JUDGMENT

Based upon the Findings of Fact and Conclusions of Law heretofore set forth, judgment is entered for Ariel Bankert against the United States of America in the sum of $393,000.00, and judgment is further entered on behalf of Kimberly Bankert against the United States of America in the sum of $200,000.00.

All Citations

937 F.Supp. 1169

Footnotes

1 This finding is not particularly pertinent in light of testimony by the obstetrician that he did not consider the policy as a basis for his actions.

2 While Dr. Rupe in her deposition initially did not recall whether she discussed the risks and benefits with the Bankerts prior to the administering of pitocin, she testified at trial that after thinking about it, she now knows she discussed it with Mrs. Bankert. The court, however, accepts the testimony of Mrs. Bankert that she was not consulted.

3 Before a vaginal delivery can occur, the patient must achieve 10 centimeters of dilation.

4 As noted earlier, the alleged statement about a pact is not particularly relevant inasmuch as Dr. Nelson took the position in his testimony that the unwritten policy was not a factor in his decision to continue with labor.

5 Stat pages are designed to be used in cases of emergency and to communicate to a physician that he or she respond immediately and urgently to the page.

6 Dr. Nelson testified that he never received a stat page to Kimberly Bankert's room. He testified that he “was up doing a consultation on the surgery floor at the other end of the hospital ... and I got just a page, ‘Dr. Nelson please call labor and delivery.’ ” It was not urgent in **any way.** It just said, ‘Please call labor and delivery.’ I was in the middle of a discussion with a general surgeon at that time, and so we finished the topic that we were talking about and I called labor and delivery. At that time I talked with one of the technicians who answered the phone. I said, ‘This is Dr. Nelson. I have been paged to call labor and delivery.’ He said, ‘I was not aware that you had been paged.’ I said, ‘please find out what's going on,’ and he put me on hold. It was probably **at least** two to three minutes later when Dr. Rupe picked up the phone, said ‘Jim, I need you here right now,’ or something to that extent. I said, ‘fine. I'll be right down,’ and I jogged down to labor and delivery. **Until Dr. Rupe actually got on the phone,** I had not received any indication that it was an emergency.

7 The APGAR score of 1 out of a potential 10 points indicates that at birth and again by five minutes of age, Ariel was making no respiratory effort, had no color, no tone, and no reflexes.

8 The APGAR scores of 1 at one minute and 1 at five minutes, however, indicate that Ariel Bankert was not being adequately or effectively ventilated in the period immediately following birth.

9 A pneumothorax of this size also causes a compromise in blood flow back to the heart and thus further impairs ventilation and circulation.

10 Kimberly Bankert expressed dissatisfaction with the educational program Ariel attended in the Prince George's County School System. The decision to home teach Ariel is contrary to the recommendation of the school intervention team which recommended more intense services based on the severity of the child's needs.

11 There is no dispute with regard to causation in this matter. Both parties agree that had Ariel been delivered by cesarean section prior to 6:30 p.m. on January 22, 1992, Ariel likely would have been born without distress and would not have suffered any physical injury. It is further clear that Ariel's injury primarily occurred “intra-partum,” which is the period after the rupture of the uterus and prior to her delivery by emergency section.

12 The Bankerts have not pursued a plan of treatment with the county school for this fall as the family is attempting to get an early 15 year retirement from the service.

13 Considering time off for summer and excluding vacations and holidays, the Court believes that Ariel is likely to be available for supplemental therapy 42 weeks during each of the next 5 years.

573 A.2d 1235
District of Columbia Court of Appeals.

In re A.C., Appellant.

No. 87–609.
|
Argued En Banc Sept. 22, 1988.
|
Decided April 26, 1990.

Synopsis

Hospital sought authority to perform caesarean delivery of terminally ill patient's baby. The Superior Court of the District of Columbia, Emmet G. Sullivan, J., permitted caesarean to be performed. The Court of Appeals, 533 A.2d 611, denied motion for stay, but subsequently granted petition for rehearing en banc, 539 A.2d 203. The Court of Appeals, Terry, J., held that where patient pregnant with viable fetus is near death, question of what is to be done is to be decided by patient, unless patient is incompetent or otherwise unable to give informed consent to proposed course of medical treatment, in which case her decision must be ascertained through procedure known as substituted judgment.

Vacated and remanded.

Belson, J., concurred in part, dissented in part, and filed opinion.

Attorneys and Law Firms

***1236** Robert E. Sylvester, Washington, D.C., and Lynn M. Paltrow, with whom Dawn Johnsen, Janet Benshoof, New York City, Rachael N. Pine, Leslie A. Harris, Arthur B. Spitzer, and Elizabeth Symonds, Washington, D.C., were on the brief, for appellant A.C.

Barbara F. Mishkin, with whom Steven J. Routh and Katie G. Lewis, Washington, D.C., were on the brief, for appellee L.M.C.

Vincent C. Burke, III, with whom Jack M.H. Frazier, Washington, D.C., was on the brief, for appellee George Washington University.

Carter G. Phillips, Washington, D.C., with whom Elizabeth H. Esty, Mark E. Haddad, Boston, Mass., David Orentlicher, Washington, D.C., Kirk B. Johnson, Edward B. Hirshfeld, Chicago, Ill., Ann E. Allen, John Lewis Smith, III and James E. Cervenak, Washington, D.C., were on the brief, for the American Medical Ass'n, the American College of Obstetricians and Gynecologists, and the Medical Soc. of the Dist. of Columbia, as amici curiae.

Frederick D. Cooke, Jr., Corp. Counsel, and Charles L. Reischel, Deputy Corp. Counsel, Washington, D.C., filed a statement in lieu of brief, for appellee Dist. of Columbia.

Sarah E. Burns, Washington, D.C., Alison C. Wetherfield, Marion B. Stillson, and Dale Schroedel filed a brief, for the NOW Legal Defense and Educ. Fund, et al., as amici curiae.

Lawrence J. Nelson and H. Westley Clark filed a brief, for the American Soc. of Law and Medicine, et al., as amici curiae.

Loren Kieve, Washington, D.C., John H. Hall, Mary Sue Henifin, Walter J. Walsh, James B. Henly, New York City, and Nadine Taub, Newark, N.J., filed a brief, for ***1237** the American Public Health Ass'n as amicus curiae.

James M. Thunder, Cleveland, Ohio, Clarke D. Forsythe, Chicago, Ill., Ann–Louise Lohr, and Edward R. Grant filed a brief, for the Americans United for Life Legal Defense Fund as amicus curiae.

Mark E. Chopko and Helen M. Alvare, Philadelphia, Pa., filed a brief, for the United States Catholic Conference as amicus curiae.

Giles R. Scofield, III, and Nancy D. Polikoff filed a memorandum, for Concern for Dying as amicus curiae.

Fenella Rouse, Elena Cohen, New York City, M. Rose Gasner, and Mark D. Schneider, Washington, D.C., filed a memorandum, for the Soc. for the Right to Die as amicus curiae.

Before ROGERS, Chief Judge,[*] NEWMAN, FERREN, BELSON, TERRY, STEADMAN and SCHWELB, Associate Judges, and MACK, Senior Judge.[**]

ON HEARING EN BANC

TERRY, Associate Judge:

This case comes before the court for the second time. In *In re A.C.,* 533 A.2d 611 (D.C.1987), a three-judge motions division denied a motion to stay an order of the trial court which had authorized a hospital to perform a caesarean

section on a dying woman in an effort to save the life of her unborn child. The operation was performed, but both the mother and the child died. A few months later, the court ordered the case heard en banc and vacated the opinion of the motions division. *In re A.C.,* 539 A.2d 203 (D.C.1988). Although the motions division recognized that, as a practical matter, it "decided the entire matter when [it] denied the stay," 533 A.2d at 613, the en banc court has nevertheless heard the full case on the merits. [1]

We are confronted here with two profoundly difficult and complex issues. First, we must determine who has the right to decide the course of medical treatment for a patient who, although near death, is pregnant with a viable fetus. Second, we must establish how that decision should be made if the patient cannot make it for herself—more specifically, how a court should proceed when faced with a pregnant patient, *in extremis,* who is apparently incapable of making an informed decision regarding medical care for herself and her fetus. We hold that in virtually all cases the question of what is to be done is to be decided by the patient—the pregnant woman—on behalf of herself and the fetus. If the patient is incompetent or otherwise unable to give an informed consent to a proposed course of medical treatment, then her decision must be ascertained through the procedure known as substituted judgment. Because the trial court did not follow that procedure, we vacate its order and remand the case for further proceedings. [2]

***1238** I

This case came before the trial court when George Washington University Hospital petitioned the emergency judge in chambers for declaratory relief as to how it should treat its patient, A.C., who was close to death from cancer and was twenty-six and one-half weeks pregnant with a viable fetus. After a hearing lasting approximately three hours, which was held at the hospital (though not in A.C.'s room), the court ordered that a caesarean section be performed on A.C. to deliver the fetus. Counsel for A.C. immediately sought a stay in this court, which was unanimously denied by a hastily assembled division of three judges. *In re A.C.,* 533 A.2d 611 (D.C.1987). The caesarean was performed, and a baby girl, L.M.C., was delivered. Tragically, the child died within two and one-half hours, and the mother died two days later.

Counsel for A.C. now maintain that A.C. was competent and that she made an informed choice not to have the caesarean performed. Given this view of the facts, they argue that it was error for the trial court to weigh the state's interest in preserving the potential life of a viable fetus against A.C.'s interest in having her decision respected. They argue further that, even if the substituted judgment procedure had been followed, the evidence would necessarily show that A.C. would not have wanted the caesarean section. Under either analysis, according to these arguments, the trial court erred in subordinating A.C.'s right to bodily integrity in favor of the state's interest in potential life. Counsel for the hospital and for L.M.C. contend, on the other hand, that A.C. was incompetent to make her own medical decisions and that, under the substituted judgment procedure, the evidence clearly established that A.C. would have consented to the caesarean. In the alternative, counsel for L.M.C. argues that even if L.M.C.'s interests and those of the state were in conflict with A.C.'s wishes, it was proper for the trial court to balance their interests and resolve the conflict in favor of surgical intervention.

We do not accept any of these arguments because the evidence, realistically viewed, does not support them.

II

A.C. was first diagnosed as suffering from cancer at the age of thirteen. In the ensuing years she underwent major surgery several times, together with multiple radiation treatments and chemotherapy. A.C. married when she was twenty-seven, during a period of remission, and soon thereafter she became pregnant. She was excited about her pregnancy and very much wanted the child. Because of her medical history, she was referred in her fifteenth week of pregnancy to the high-risk pregnancy clinic at George Washington University Hospital.

On Tuesday, June 9, 1987, when A.C. was approximately twenty-five weeks pregnant, she went to the hospital for a scheduled check-up. Because she was experiencing pain in her back and shortness of breath, an x-ray was taken, revealing an apparently inoperable tumor which nearly filled her right lung. On Thursday, June 11, A.C. was admitted to the hospital as a patient. By Friday her condition had temporarily improved, and when asked if she really wanted to have her baby, she replied that she did.

Over the weekend A.C.'s condition worsened considerably. Accordingly, on Monday, June 15, members of the medical staff treating A.C. assembled, along with her family, in A.C.'s

room. The doctors then informed her that her illness was terminal, and A.C. agreed to palliative treatment designed to extend her life until at least her twenty-eighth week of pregnancy. The "potential outcome [for] the fetus," according to the doctors, would be much better at twenty-eight weeks than at twenty-six weeks if it were necessary to "intervene." A.C. knew that the palliative treatment she ***1239** had chosen presented some increased risk to the fetus, but she opted for this course both to prolong her life for at least another two weeks and to maintain her own comfort. When asked if she still wanted to have the baby, A.C. was somewhat equivocal, saying "something to the effect of 'I don't know, I think so.' " As the day moved toward evening, A.C.'s condition grew still worse, and at about 7:00 or 8:00 p.m. she consented to intubation to facilitate her breathing.

The next morning, June 16, the trial court convened a hearing at the hospital in response to the hospital's request for a declaratory judgment. The court appointed counsel for both A.C. and the fetus, and the District of Columbia was permitted to intervene for the fetus as *parens patriae.* The court heard testimony on the facts as we have summarized them, and further testimony that at twenty-six and a half weeks the fetus was viable, *i.e.,* capable of sustained life outside of the mother, given artificial aid. A neonatologist, Dr. Maureen Edwards, testified that the chances of survival for a twenty-six-week fetus delivered at the hospital might be as high as eighty percent, but that this particular fetus, because of the mother's medical history, had only a fifty to sixty percent chance of survival.[3] Dr. Edwards estimated that the risk of substantial impairment for the fetus, if it were delivered promptly, would be less than twenty percent. However, she noted that the fetus' condition was worsening appreciably at a rapid rate, and another doctor—Dr. Alan Weingold, an obstetrician who was one of A.C.'s treating physicians—stated that any delay in delivering the child by caesarean section lessened its chances of survival.

Regarding A.C.'s ability to respond to questioning and her prognosis, Dr. Louis Hamner, another treating obstetrician, testified that A.C. would probably die within twenty-four hours "if absolutely nothing else is done.... As far as her ability to interact, she has been heavily sedated in order to maintain her ventilatory function. She will open her eyes sometimes when you are in the room, but as far as her being able to ... carry on a meaningful-type conversation ... at this point, I don't think that is reasonable." When asked whether reducing her medication to "permit recovery of enough cognitive function on her part that we could get any sense from her as to what her preference would be as to therapy," Dr. Hamner replied, "I don't think so. I think her respiratory status has deteriorated to the point where she is [expending] an enormous amount of energy just to keep the heart going." Dr. Weingold, asked the same question, gave a similar answer: that A.C.'s few remaining hours of life "will be shortened by attempting to raise her level of consciousness because that is what is keeping her, in a sense, physiologically compliant with the respirator. If you remove that, then I think that will shorten her survival."

There was no evidence before the court showing that A.C. consented to, or even contemplated, a caesarean section before her twenty-eighth week of pregnancy. There was, in fact, considerable dispute as to whether she would have consented to an immediate caesarean delivery at the time the hearing was held. A.C.'s mother opposed surgical intervention, testifying that A.C. wanted "to live long enough to hold that baby" and that she expected to do so, "even though she knew she was terminal." Dr. Hamner testified that, given A.C.'s medical problems, he did not think she would have chosen to deliver a child with a substantial degree of impairment. Asked whether A.C. had been "confronted with the question of what to do if there were a choice that ultimately had to be made between her own life expectancy and that of her fetus," he replied that the question "was addressed [but] at a later gestational age. We had talked about the possibility at twenty-eight weeks, if she had to be intubated, if this was a terminal event, would we intervene, and the expression was yes, that we would, because we felt at ***1240** twenty-eight weeks we had much more to offer as far as taking care of the child." Finally, Dr. Hamner stated that "the department as a whole" concluded that "we should abide by the wishes of the family." Dr. Lawrence Lessin, an oncologist and another of A.C.'s treating physicians, testified that in meetings with A.C. he had heard nothing to indicate that, if faced with the decision, she would have refused permission for a caesarean section. Dr. Weingold opposed the operation because he believed A.C. had not seriously considered that she might not survive the birth of her baby. Dr. Weingold made explicit what was implicit in Dr. Hamner's testimony: that "in dealing with her, a message that was sent to her was that the earliest we would feel comfortable in intervening, should there be indication as to either maternal or fetal grounds, would be twenty-eight weeks."

After hearing this testimony[4] and the arguments of counsel, the trial court made oral findings of fact. It found, first, that A.C. would probably die, according to uncontroverted

medical testimony, "within the next twenty-four to forty-eight hours"; second, that A.C. was "pregnant with a twenty-six and a half week viable fetus who, based upon uncontroverted medical testimony, has approximately a fifty to sixty percent chance to survive if a caesarean section is performed as soon as possible"; third, that because the fetus was viable, "the state has [an] important and legitimate interest in protecting the potentiality of human life"; and fourth, that there had been some testimony that the operation "may very well hasten the death of [A.C.]," but that there had also been testimony that delay would greatly increase the risk to the fetus and that "the prognosis is not great for the fetus to be delivered post-mortem...." Most significantly, the court found:

> The court is of the view that it does not clearly know what [A.C.'s] present views are with respect to the issue of whether or not the child should live or die. She's presently unconscious. As late as Friday of last week, she wanted the baby to live. As late as yesterday, she did not know for sure.

Having made these findings of fact and conclusions of law, and expressly relying on *In re Madyun,* 114 Daily Wash.L.Rptr. 2233 (D.C.Super.Ct. July 26, 1986), [5] the court ordered that a caesarean section be performed to deliver A.C.'s child.

The court's decision was then relayed to A.C., who had regained consciousness. When the hearing reconvened later in the day, Dr. Hamner told the court:

> I explained to her essentially what was going on.... I said it's been deemed we should intervene on behalf of the baby by caesarean section and it would give it the only possible chance of it living. Would you agree to this procedure? *She said yes.* I said, do you realize that you may not survive the surgical procedure? *She said yes.* And I repeated the two questions to her again [and] asked her did she understand. *She said yes.* [Emphasis added.]

When the court suggested moving the hearing to A.C.'s bedside, Dr. Hamner discouraged the court from doing so, but he and Dr. Weingold, together with A.C.'s mother and husband, went to A.C.'s room to confirm her consent to the procedure. What happened then was recounted to the court a few minutes later:

> THE COURT: Will you bring us up to date? Did you have a conversation with [A.C.]?
>
> DR. WEINGOLD: I did not. I observed the conversation between Dr. Hamner and [A.C.]. Dr. Hamner went into the room to attempt to verify his previous discussion with the patient, with the patient's husband at her right hand and her mother at her left hand. He, to my satisfaction, clearly communicated with [A.C.]. She understood.
>
> THE COURT: You could hear what the parties were saying to one another?
>
> ***1241** DR. WEINGOLD: She does not make sound because of the tube in her windpipe. She nods and she mouths words. One can see what she's saying rather readily. She asked whether she would survive the operation. She asked [Dr.] Hamner if he would perform the operation. He told her he would only perform it if she authorized it but it would be done in any case. She understood that. She then seemed to pause for a few moments and then very clearly mouthed words several times, *I don't want it done. I don't want it done.* Quite clear to me.
>
> I would obviously state the obvious and that is this is an environment in which, from my perspective as a physician, this would not be an informed consent one way or the other. She's under tremendous stress with the family on both sides, but I'm satisfied that I heard clearly what she said.
>
> THE COURT: Dr. Hamner, did you wish to elaborate?
>
> DR. HAMNER: That's accurate. I noticed she was much more alert than she had been earlier in the day and was responding to the nurses in the room as well as to all the physicians and went through the same sequence Dr. Weingold noted. [Emphasis added.]

Dr. Weingold later qualified his opinion as to A.C.'s ability to give an informed consent, stating that he thought the environment for an informed consent was non-existent because A.C. was in intensive care, flanked by a weeping husband and mother. He added:

> I think she's in contact with reality, clearly understood who Dr. Hamner was. Because of her attachment to him [she] wanted him to perform the surgery. Understood he would not unless she consented and did not consent.
>
> That is, in my mind, very clear evidence that she is responding, understanding, and is capable of making such decisions.

Dr. Hamner stated that the sedation had "worn off enough for her to wake up to this state" and that "the level of drugs in her body is much different from several hours ago." Consequently, despite A.C.'s continued sedation, Dr. Weingold said that she was "quite reactive," and Dr. Hamner concurred.

After hearing this new evidence, the court found that it was "still not clear what her intent is" and again ordered that a caesarean section be performed. A.C.'s counsel sought a stay in this court, which was denied. *In re A.C.,* 533 A.2d 611, 613 (D.C.1987). The operation took place, but the baby lived for only a few hours, and A.C. succumbed to cancer two days later.

III

The reader may wonder why we are issuing an en banc opinion in this case despite its apparent mootness. [6] The case is moot only in the sense that the surgery which was ordered in this case has been performed, and no decision of ours can put the parties in the same position in which they found themselves before the trial court's order was issued. Otherwise the case is not moot, because collateral consequences will flow from any decision we make in this appeal.

The personal representative of A.C.'s estate has filed an action separate from this appeal against the hospital, based on the events leading to the trial court's order in this case. In these circumstances we adhere to our prior decisions refusing to dismiss an appeal as moot when resolution of the legal issues might affect a separate action, actual or prospective, between the parties. *See Kopff v. District of Columbia Alcoholic Beverage Control Board, supra* note 6, 381 A.2d at 1378; *Saunders v. First National Realty Corp.,* 245 A.2d 836, 837 (D.C.1968), *aff'd in relevant part* ***1242** *sub nom. Javins v. First National Realty Corp.,* 138 U.S.App.D.C. 369, 371 n. 5, 428 F.2d 1071, 1073 n. 5, *cert. denied,* 400 U.S. 925, 91 S.Ct. 186, 27 L.Ed.2d 185 (1970); *Brown v. Southall Realty Co.,* 237 A.2d 834, 835–836 (D.C.1968); *cf. Super Tire Engineering Co. v. McCorkle,* 416 U.S. 115, 121–122, 94 S.Ct. 1694, 1697–98, 40 L.Ed.2d 1 (1974). Any right of action that A.C. may have had against the hospital as a result of the events that culminated in the trial court's order has probably survived her and may still be asserted by her estate (assuming that it is not otherwise subject to dismissal or barred for other reasons). *See* D.C.Code § 12–101 (1989) (survival statute).

Even if this case were truly moot and had no collateral consequences, we would nevertheless elect to hear it because what occurred here is "capable of repetition, yet evading review." *Southern Pacific Terminal Co. v. ICC,* 219 U.S. 498, 515, 31 S.Ct. 279, 283, 55 L.Ed. 310 (1911); *see Lynch v. United States,* 557 A.2d 580, 582–583 (D.C.1989) (en banc); *United States v. Edwards,* 430 A.2d 1321, 1324 n. 2 (D.C.1981) (en banc), *cert. denied,* 455 U.S. 1022, 102 S.Ct. 1721, 72 L.Ed.2d 141 (1982). *See generally Alton & Southern Ry. v. International Ass'n of Machinists,* 150 U.S.App.D.C. 36, 463 F.2d 872 (1972). The challenged action here is not just the trial court's order but the hospital's handling of the medical emergency, which necessarily was too short to be fully litigated, given A.C.'s rapidly declining condition. Additionally, this is a suit for a declaratory judgment, in which the plaintiff is not A.C. but the hospital. Because the hospital operates a high-risk pregnancy clinic, it will in all likelihood again face a situation in which a pregnant but dying patient is either incapable of consenting to treatment or affirmatively refusing treatment. Indeed, any hospital in the District of Columbia may find itself in the same situation, even one without a specialized facility for such patients. There is thus a reasonable expectation that the challenged action in this case —*i.e.,* the hospital's decision to seek judicial authorization for a medical procedure affecting a pregnant patient *in extremis* —may occur again. *See Honig v. Doe,* 484 U.S. 305, 108 S.Ct. 592, 601–602 & n. 6, 98 L.Ed.2d 686 (1988). Accordingly, we conclude that we should entertain this appeal in the exercise of our discretion, even assuming that it is partially or wholly moot.

IV

Although we decide this case on the merits of the legal issues, it is important to remember that factual disputes dominate this controversy and determine how the legal issues are framed. It is, of course, beyond dispute that the trial court's findings of fact are binding on this court unless clearly erroneous. D.C.Code § 17–305(a) (1989); *see, e.g., Bell v. Jones,* 523 A.2d 982, 992 (D.C.1986). Sitting as an appellate court, we cannot engage in fact-finding. *See Harmatz v. Zenith Radio Corp.,* 265 A.2d 291, 292 (D.C.1970). With these preliminary observations, we proceed to address the issues as we understand them.

A. *Informed Consent and Bodily Integrity*

A number of learned articles have been written about the propriety or impropriety of court-ordered caesarean sections. *E.g.,* Johnsen, *The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy, and Equal Protection,* 95 YALE L.J. 599 (1986); Kolder, Gallagher & Parsons, *Court–Ordered Obstetrical Interventions,* 316 NEW ENG. J. MED. 1192 (1987) (hereafter *Obstetrical Interventions*); Rhoden, *The Judge in the Delivery Room: The Emergence of Court–Ordered Caesareans,* 74 CAL.L.REV. 1951 (1986); Robertson, *Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth,* 69 VA.L.REV. 405 (1983). Commentators have also considered how medical decisions for incompetent persons which may involve some detriment or harm to them should be made. *E.g.,* Pollock, *Life and Death Decisions: Who Makes Them and by What Standards?,* 41 RUTGERS L.REV. 505, 518–540 (1989); Robertson, *Organ Donations by Incompetents and the Substituted Judgment* ***1243** *Doctrine,* 76 COLUM.L.REV. 48 (1976). These and other articles demonstrate the complexity of medical intervention cases, which become more complex with the steady advance of medical technology. From a recent national survey, it appears that over the five years preceding the survey there were thirty-six attempts to override maternal refusals of proposed medical treatment, and that in fifteen instances where court orders were sought to authorize caesarean interventions, thirteen such orders were granted. *Obstetrical Interventions, supra,* 316 NEW ENG. J. MED. at 1192–1193. *Compare* Goldberg, *Medical Choices During Pregnancy: Whose Decision Is It Anyway?,* 41 RUTGERS L.REV. 591, 609 (1989) (finding twelve such cases). Nevertheless, there is only one published decision from an appellate court that deals with the question of when, or even whether, a court may order a caesarean section: *Jefferson v. Griffin Spalding County Hospital Authority,* 247 Ga. 86, 274 S.E.2d 457 (1981).

Jefferson is of limited relevance, if any at all, to the present case. In *Jefferson* there was a competent refusal by the mother to undergo the proposed surgery, but the evidence showed that performance of the caesarean was in the medical interests of both the mother and the fetus. [7] In the instant case, by contrast, the evidence is unclear as to whether A.C. was competent when she mouthed her apparent refusal of the caesarean ("I don't want it done"), and it was generally assumed that while the surgery would most likely be highly beneficial to the fetus, it would be dangerous for the mother. Thus there was no clear maternal-fetal conflict in this case arising from a competent decision by the mother to forego a procedure for the benefit of the fetus. The procedure may well have been against A.C.'s medical interest, but if she was competent and given the choice, she may well have consented to an operation of significant risk to herself in order to maximize her fetus' chance for survival. From the evidence, however, we simply cannot tell whether she would have consented or not.

Thus our analysis of this case begins with the tenet common to all medical treatment cases: that any person has the right to make an informed choice, if competent to do so, to accept or forego medical treatment. The doctrine of informed consent, based on this principle and rooted in the concept of bodily integrity, is ingrained in our common law. *See Crain v. Allison,* 443 A.2d 558, 561–562 (D.C.1982); *Canterbury v. Spence,* 150 U.S.App.D.C. 263, 271, 464 F.2d 772, 780, *cert. denied,* 409 U.S. 1064, 93 S.Ct. 560, 34 L.Ed.2d 518 (1972); *Schloendorff v. Society of New York Hospital,* 211 N.Y. 125, 127, 105 N.E. 92, 93 (1914). Under the doctrine of informed consent, a physician must inform the patient, "at a minimum," of "the nature of the proposed treatment, any alternative treatment procedures, and the nature and degree of risks and benefits inherent in undergoing and in abstaining from the proposed treatment." *Crain v. Allison, supra,* 443 A.2d at 562 (footnote omitted). To protect the right of every person to bodily integrity, courts uniformly hold that a surgeon who performs an operation without the patient's consent may be guilty of a battery, *Canterbury v. Spence, supra,* 150 U.S.App.D.C. at 274, 464 F.2d at 783, or that if the surgeon obtains an insufficiently informed consent, he or she may be liable for negligence. *Crain v. Allison, supra,* 443 A.2d at 561–562. Furthermore, the right to informed consent "also encompasses a right to informed refusal." *In*

re Conroy, 98 N.J. 321, 336, 486 A.2d 1209, 1222 (1985) (citation omitted).

In the same vein, courts do not compel one person to permit a significant intrusion ***1244** upon his or her bodily integrity for the benefit of another person's health. *See, e.g., Bonner v. Moran,* 75 U.S.App.D.C. 156, 157, 126 F.2d 121, 122 (1941) (parental consent required for skin graft from fifteen-year-old for benefit of cousin who had been severely burned); *McFall v. Shimp,* 10 Pa.D. & C.3d 90 (Allegheny County Ct.1978). In *McFall* the court refused to order Shimp to donate bone marrow which was necessary to save the life of his cousin, McFall:

> The common law has consistently held to a rule which provides that one human being is under no legal compulsion to give aid or to take action to save another human being or to rescue.... For our law to *compel* defendant to submit to an intrusion of his body would change every concept and principle upon which our society is founded. To do so would defeat the sanctity of the individual, and would impose a rule which would know no limits, and one could not imagine where the line would be drawn.

Id. at 91 (emphasis in original). Even though Shimp's refusal would mean death for McFall, the court would not order Shimp to allow his body to be invaded. It has been suggested that fetal cases are different because a woman who "has chosen to lend her body to bring [a] child into the world" has an enhanced duty to assure the welfare of the fetus, sufficient even to require her to undergo caesarean surgery. Robertson, *Procreative Liberty, supra,* 69 VA.L.REV. at 456. Surely, however, a fetus cannot have rights in this respect superior to those of a person who has already been born. [8]

Courts have generally held that a patient is competent to make his or her own medical choices when that patient is capable of "the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each." *Canterbury v. Spence, supra,* 150 U.S.App.D.C. at 271, 464 F.2d at 780. Thus competency in a case such as this turns on the patient's ability to function as a decision-maker, acting in accordance with her preferences and values. *United States v. Charters,* 829 F.2d 479, 495–497 & nn. 23–26 (4th Cir.1987) (competency to make treatment decisions depends on whether the patient is able to make a rational choice based on reason), *on rehearing en banc,* 863 F.2d 302 (1988); *In re Farrell,* 108 N.J. 335, 354 & n. 7, 529 A.2d 404, 413 & n. 7 (1987) ("A competent patient has a clear understanding of the nature of his or her illness and prognosis, and of the risks and benefits of the proposed treatment, and has the capacity to reason and make judgments about that information" (citations omitted)); *accord,* PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE–SUSTAINING TREATMENTTTTTTTTTTTTTTTTT 123 (1983) (hereafter 1983 PRESIDENT'S COMMISSION REPORT); 1 PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS 171–172 (1982) (hereafter 1982 PRESIDENT'S COMMISSION REPORT).

This court has recognized as well that, above and beyond common law protections, the right to accept or forego medical treatment is of constitutional magnitude. *See In re Bryant,* 542 A.2d 1216, 1218 (D.C.1988); *In re Boyd,* 403 A.2d 744, 748 (D.C.1979); *In re Osborne,* 294 A.2d 372 (D.C.1972). Other courts also have found a basis in the Constitution for refusing medical treatment. *E.g., United States v. Charters, supra,* 829 F.2d at 491 & nn. 18–19 ***1245** ("[t]he right to be free of unwanted physical invasions" is constitutionally protected); *Bee v. Greaves,* 744 F.2d 1387, 1392–1393 (10th Cir.1984) (same), *cert. denied,* 469 U.S. 1214, 105 S.Ct. 1187, 84 L.Ed.2d 334 (1985); *Tune v. Walter Reed Army Medical Hospital,* 602 F.Supp. 1452, 1456 (D.D.C.1985) (competent patient has right to order removal of life-sustaining medical systems); *Rasmussen ex rel. Mitchell v. Fleming,* 154 Ariz. 207, 215, 741 P.2d 674, 681–682 (1987) (constitutional right of privacy encompasses the right to refuse life-sustaining care); *see also John F. Kennedy Memorial Hospital, Inc. v. Bludworth,* 452 So.2d 921, 923–926 (Fla.1984) (incompetent persons have the right to discontinue life-sustaining care); *Superintendent of Belchertown State School v. Saikewicz,* 373 Mass. 728, 739, 370 N.E.2d 417, 426 (1977) (incompetent person may decline medical treatment for incurable illness); *In re Conroy, supra,* 98 N.J. at 336–37, 486 A.2d at 1222–1223, 1229 (competent persons have constitutional

right to refuse medical treatment, and persons who become incompetent retain that right).

Decisions of the Supreme Court, while not explicitly recognizing a right to bodily integrity, seem to assume that individuals have the right, depending on the circumstances, to accept or refuse medical treatment or other bodily invasion. *See, e.g., Winston v. Lee,* 470 U.S. 753, 105 S.Ct. 1611, 84 L.Ed.2d 662 (1985); *Schmerber v. California,* 384 U.S. 757, 86 S.Ct. 1826, 16 L.Ed.2d 908 (1966); *Rochin v. California, supra* note 8; *cf. Union Pacific Ry. v. Botsford,* 141 U.S. 250, 251, 11 S.Ct. 1000, 1001, 35 L.Ed. 734 (1891) ("No right is held more sacred, or is more carefully guarded, *by the common law,* than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law" (emphasis added)). In *Winston v. Lee, supra,* a robbery suspect challenged the state's right to compel him to submit to surgery for the removal of a bullet which was lodged in a muscle in his chest. The Court noted that the proposed surgery, which would require a general anesthetic, "would be an 'extensive' intrusion on respondent's personal privacy and bodily integrity" and a "virtually total divestment of respondent's ordinary control over surgical probing beneath his skin," 470 U.S. at 764–765, 105 S.Ct. at 1619 (citation omitted), and held that, without the patient-suspect's consent, the surgery was constitutionally impermissible. Nevertheless, even in recognizing a right to refuse medical treatment or state-imposed surgery, neither *Winston* nor any other Supreme Court decision holds that this right of refusal is absolute. Rather, in discussing the constitutional "reasonableness of surgical intrusions beneath the skin," the Court said in *Winston* that the Fourth Amendment "neither forbids nor permits all such intrusions...." *Id.* at 760, 105 S.Ct. at 1616 (citing *Schmerber v. California, supra*); *see also Jacobson v. Massachusetts,* 197 U.S. 11, 25 S.Ct. 358, 49 L.Ed. 643 (1905) (upholding compulsory smallpox vaccinations over religious objections). [9]

This court and others, while recognizing the right to accept or reject medical treatment, have consistently held that the ***1246** right is not absolute. *E.g., In re Boyd, supra,* 403 A.2d at 749–750; *In re Osborne, supra,* 294 A.2d at 374; *In re President & Directors of Georgetown College, Inc.,* 118 U.S.App.D.C. 80, 331 F.2d 1000, *cert. denied,* 377 U.S. 978, 84 S.Ct. 1883, 12 L.Ed.2d 746 (1964); *Rasmussen ex rel. Mitchell v. Fleming, supra,* 154 Ariz. at 216, 741 P.2d at 683; *In re Conroy, supra,* 98 N.J. at 337, 486 A.2d at 1223; *cf. Hughes v. United States,* 429 A.2d 1339 (D.C.1981) (upholding as reasonable a minor surgical intrusion to remove bullets from a criminal suspect); [10] *United States v. Crowder,* 177 U.S.App.D.C. 165, 543 F.2d 312 (1976) (same), *cert. denied,* 429 U.S. 1062, 97 S.Ct. 788, 50 L.Ed.2d 779 (1977). [11] In some cases, especially those involving life-or-death situations or incompetent patients, the courts have recognized four countervailing interests that may involve the state as *parens patriae:* preserving life, preventing suicide, maintaining the ethical integrity of the medical profession, and protecting third parties. *See, e.g., In re Boyd, supra,* 403 A.2d at 748 n. 9; *Brophy v. New England Sinai Hospital, Inc.,* 398 Mass. 417, 431–433, 497 N.E.2d 626, 634 (1986); *Saikewicz, supra,* 373 Mass. at 737, 370 N.E.2d at 425; *In re Farrell, supra,* 108 N.J. at 350, 529 A.2d at 410–411. Neither the prevention of suicide [12] nor the integrity of the medical profession [13] has any bearing on this case. Further, the state's interest in preserving life must be truly compelling to justify overriding a competent person's right to refuse medical treatment. *In re Osborne, supra,* 294 A.2d at 374–375; *Tune v. Walter Reed Army Medical Hospital, supra,* 602 F.Supp. at 1455–1456. This is equally true for incompetent patients, who have just as much right as competent patients to have their decisions made while competent respected, even in a substituted judgment framework. *See In re Boyd, supra,* 403 A.2d at 750; *John F. Kennedy Memorial Hospital, Inc. v. Bludworth, supra,* 452 So.2d at 923–924; *Saikewicz, supra,* 373 Mass. at 739, 370 N.E.2d at 427–428; *In re Conroy, supra,* 98 N.J. at 343, 486 A.2d at 1229.

In those rare cases in which a patient's right to decide her own course of treatment has been judicially overridden, courts have usually acted to vindicate the state's interest in protecting third parties, even if in fetal state. *See Jefferson v. Griffin Spalding County Hospital Authority, supra* (ordering that caesarean section be performed on a woman in her thirty-ninth week of pregnancy to save both the mother and the fetus); *Raleigh Fitkin–Paul Morgan Memorial Hospital v. Anderson,* 42 N.J. 421, 201 A.2d 537 (ordering blood transfusions over the objection of a Jehovah's Witness, in her thirty-second week of pregnancy, to save her life and that of the fetus), *cert. denied,* 377 U.S. 985, 84 S.Ct. 1894, 12 L.Ed.2d 1032 (1964); *In re Jamaica Hospital,* 128 Misc.2d 1006, 491 N.Y.S.2d 898 (Sup.Ct.1985) (ordering the transfusion of blood to a Jehovah's Witness eighteen weeks pregnant, who objected on religious grounds, and finding that the ***1247** state's interest in the not-yet-viable fetus outweighed the patient's interests); *Crouse Irving Memorial*

Hospital, Inc. v. Paddock, 127 Misc.2d 101, 485 N.Y.S.2d 443 (Sup.Ct.1985) (ordering transfusions as necessary over religious objections to save the mother and a fetus that was to be prematurely delivered); *cf. In re President & Directors of Georgetown College, Inc., supra,* 118 U.S.App.D.C. at 88, 331 F.2d at 1008 (ordering a transfusion, *inter alia,* because of a mother's parental duty to her living minor children). *But see Taft v. Taft,* 388 Mass. 331, 446 N.E.2d 395 (1983) (vacating an order which required a woman in her fourth month of pregnancy to undergo a "purse-string" operation, on the ground that there were no compelling circumstances to justify overriding her religious objections and her constitutional right of privacy).

What we distill from the cases discussed in this section is that every person has the right, under the common law and the Constitution, to accept or refuse medical treatment. [14] This right of bodily integrity belongs equally to persons who are competent and persons who are not. Further, it matters not what the quality of a patient's life may be; the right of bodily integrity is not extinguished simply because someone is ill, or even at death's door. To protect that right against intrusion by others—family members, doctors, hospitals, or anyone else, however well-intentioned—we hold that a court must determine the patient's wishes by any means available, and must abide by those wishes unless there are truly extraordinary or compelling reasons to override them. *In re Osborne, supra.* When the patient is incompetent, or when the court is unable to determine competency, the substituted judgment procedure must be followed.

From the record before us, we simply cannot tell whether A.C. was ever competent, after being sedated, to make an informed decision one way or the other regarding the proposed caesarean section. The trial court never made any finding about A.C.'s competency to decide. Undoubtedly, during most of the proceedings below, A.C. was incompetent to make a treatment decision; that is, she was unable to give an informed consent based on her assessment of the risks and benefits of the contemplated surgery. The court knew from the evidence that A.C. was sedated and unconscious, and thus it could reasonably have found her incompetent to render an informed consent; however, it made no such finding. On the other hand, there was no clear evidence that A.C. was competent to render an informed consent after the trial court's initial order was communicated to her.

We think it is incumbent on any trial judge in a case like this, unless it is impossible to do so, to ascertain whether a patient is competent to make her own medical decisions. Whenever possible, the judge should personally attempt to speak with the patient and ascertain her wishes directly, rather than relying exclusively on hearsay evidence, even from doctors. [15] *See In re Osborne, surpa,* 294 A.2d at 374; *In re President & Directors of Georgetown College, Inc., supra,* 118 U.S.App.D.C. at 87, 331 F.2d at 1007. It is improper to presume that a patient is incompetent. *United States v. Charters, supra,* 829 F.2d at 495. We have no reason to believe that, if competent, A.C. would or would not have refused consent to a caesarean. We hold, however, that without a competent refusal from A.C. to go forward with the surgery, and without a finding through substituted judgment that A.C. would not have consented to the surgery, it was error for the trial court to proceed to a balancing analysis, weighing the rights of A.C. against the interests of the state.

***1248** There are two additional arguments against overriding A.C.'s objections to caesarean surgery. First, as the American Public Health Association cogently states in its *amicus curiae* brief:

> Rather than protecting the health of women and children, court-ordered caesareans erode the element of trust that permits a pregnant woman to communicate to her physician—without fear of reprisal—all information relevant to her proper diagnosis and treatment. An even more serious consequence of court-ordered intervention is that it drives women at high risk of complications during pregnancy and childbirth out of the health care system to avoid coerced treatment. [16]

Second, and even more compellingly, any judicial proceeding in a case such as this will ordinarily take place—like the one before us here—under time constraints so pressing that it is difficult or impossible for the mother to communicate adequately with counsel, or for counsel to organize an effective factual and legal presentation in defense of her liberty and privacy interests and bodily integrity. Any intrusion implicating such basic values ought not to be lightly undertaken when the mother not only is precluded from

conducting pre-trial discovery (to which she would be entitled as a matter of course in any controversy over even a modest amount of money) but also is in no position to prepare meaningfully for trial. As one commentator has noted:

> The procedural shortcomings rampant in these cases are not mere technical deficiencies. They undermine the authority of the decisions themselves, posing serious questions as to whether judges can, in the absence of genuine notice, adequate representation, explicit standards of proof, and right of appeal, realistically frame principled and useful legal responses to the dilemmas with which they are being confronted. Certainly courts dealing with other kinds of medical decision-making conflicts have insisted both upon much more rigorous procedural standards and upon significantly more information.

Gallagher, *Prenatal Invasions and Interventions: What's Wrong with Fetal Rights,* 10 HARV.WOMEN'S L.J. 9, 49 (1987).

In this case A.C.'s court-appointed attorney was unable even to meet with his client before the hearing. By the time the case was heard, A.C.'s condition did not allow her to be present, nor was it reasonably possible for the judge to hear from her directly. The factual record, moreover, was significantly flawed because A.C.'s medical records were not before the court and because Dr. Jeffrey Moscow, the physician who had been treating A.C. for many years, was not even contacted and hence did not testify. [17] Finally, the time for legal preparation was so minimal that neither the court nor counsel mentioned the doctrine of substituted judgment, which—with benefit of briefs, oral arguments, and above all, time—we now deem critical to the outcome of this case. We cannot be at all certain that the trial judge would have reached the same decision if the testimony of Dr. Moscow and the abundant legal scholarship filed in this court had been meaningfully available to him, and if there had been enough time for him to consider and reflect on these matters as a judge ***1249** optimally should do. [18]

B. *Substituted Judgment*

In the previous section we discussed the right of an individual to accept or reject medical treatment. We concluded that if a patient is competent and has made an informed decision regarding the course of her medical treatment, that decision will control in virtually all cases. Sometimes, however, as our analysis presupposes here, a once competent patient will be unable to render an informed decision. In such a case, we hold that the court must make a substituted judgment on behalf of the patient, based on all the evidence. This means that the duty of the court, "as surrogate for the incompetent, is to determine as best it can what choice that individual, if competent, would make with respect to medical procedures." *In re Boyd, supra,* 403 A.2d at 750 (citation omitted).

Under the substituted judgment procedure, the court as decision-maker must "substitute itself as nearly as may be for the incompetent, and ... act upon the same motives and considerations as would have moved her...." *City Bank Farmers Trust Co. v. McGowan,* 323 U.S. 594, 599, 65 S.Ct. 496, 498, 89 L.Ed. 483 (1945). The concept of substituted judgment, which has its roots in English law, was intended to allow courts to make dispositions from the estates of incompetents akin to those that the incompetents would have made if competent. *See Strunk v. Strunk,* 445 S.W.2d 145, 147–148 (Ky.1969). In recent times the procedure has been used to authorize organ "donations" by incompetents, as in *Strunk,* and to prohibit the forced administration of medical treatment to incompetents, over religious objections, where life itself was not at stake. *E.g., In re Boyd, supra; United States v. Charters, supra.* Most cases involving substituted judgment, however, have arisen in the "right to die" context, and the courts have generally concluded that giving effect to the perceived decision of the incompetent is the proper course, even though doing so will result in the incompetent's death. *E.g., In re Spring,* 380 Mass. 629, 405 N.E.2d 115 (1980); *In re Jobes,* 108 N.J. 394, 529 A.2d 434 (1987); *In re Colyer,* 99 Wash.2d 114, 660 P.2d 738 (1983). *See generally Pollock, Life and Death Decisions: Who Makes Them and by What Standards?,* 41 RUTGERS L. REV. 505 (1989); Annotation, *Judicial Power to Order Discontinuance of Life–Sustaining Treatment,* 48 A.L.R. 4th 67 (1986).

We have found no reported opinion applying the substituted judgment procedure to the case of an incompetent pregnant patient whose own life may be shortened by a caesarean section, and whose unborn child's chances of survival may

hang on the court's decision. Despite this precedential void, we conclude that substituted judgment is the best procedure to follow in such a case because it most clearly respects the right of the patient to bodily integrity. Thus we reaffirm our holding in *In re Boyd,* in which we discussed how a substituted judgment should be made when a patient, although incompetent, has previously expressed objections to treatment, and we observe that many of the factors found relevant to discerning the patient's choice in *Boyd* are relevant here.

We begin with the proposition that the substituted judgment inquiry is primarily a subjective one: as nearly as possible, the court must ascertain what the patient would do if competent. *In re Boyd, supra,* 403 A.2d at 750; *In re Spring, supra,* 380 Mass. at 633, 405 N.E.2d at 119; *Saikewicz, supra,* 373 Mass. at 344, 370 N.E.2d at 431; *In re Conroy, supra,* 98 N.J. at 343, 486 A.2d at 1229. Due process strongly suggests (and may even require) that counsel or a guardian *ad litem* should be appointed for the patient unless the situation is so urgent that there is no time to do so.

Because it is the patient's decisional rights which the substituted judgment inquiry seeks to protect, courts are in accord ***1250** that the greatest weight should be given to the previously expressed wishes of the patient. This includes prior statements, either written or oral, even though the treatment alternatives at hand may not have been addressed. *See In re Boyd, supra,* 403 A.2d at 751–752 (absolute objections to treatment are highly relevant); *Brophy v. New England Sinai Hospital, Inc., supra,* 398 Mass. at 427, 497 N.E.2d at 631; *In re Conroy, supra,* 98 N.J. at 343–45, 486 A.2d at 1229–1230; *In re Dorone,* 349 Pa.Super. 59, 68, 502 A.2d 1271, 1278 (1985), *aff'd,* 517 Pa. 3, 534 A.2d 452 (1987); *see also* 1982 PRESIDENT'S COMMISSION REPORT, *supra,* at 179. The court should also consider previous decisions of the patient concerning medical treatment, especially when there may be a discernibly consistent pattern of conduct or of thought. *E.g., In re Boyd, supra,* 403 A.2d at 751; *In re Conroy, supra,* 98 N.J. at 345, 486 A.2d at 1230; *In re Dorone, supra,* 349 Pa.Super. at 68, 502 A.2d at 1278; *see also* 1983 PRESIDENT'S COMMISSION REPORT, *supra,* at 133. Thus in a case such as this it would be highly relevant that A.C. had consented to intrusive and dangerous surgeries in the past, and that she chose to become pregnant and to protect her pregnancy by seeking treatment at the hospital's high-risk pregnancy clinic. It would also be relevant that she accepted a plan of treatment which contemplated caesarean intervention at the twenty-eighth week of pregnancy, even though the possibility of a caesarean during the twenty-sixth week was apparently unforeseen. On the other hand, A.C. agreed to a plan of palliative treatment which posed a greater danger to the fetus than would have been necessary if she were unconcerned about her own continuing care. Further, when A.C. was informed of the fatal nature of her illness, she was equivocal about her desire to have the baby.

Courts in substituted judgment cases have also acknowledged the importance of probing the patient's value system as an aid in discerning what the patient would choose. We agree with this approach. *See In re Boyd, supra,* 403 A.2d at 751 (considering the patient's adherence to religious tenets); *Brophy v. New England Sinai Hospital, Inc., supra,* 398 Mass. at 427, 497 N.E.2d at 631; *In re Roe,* 383 Mass. 415, 433, 421 N.E.2d 40, 56–59 (1981); *In re Conroy, supra,* 98 N.J. at 344, 486 A.2d at 1230; *In re Dorone, supra,* 349 Pa.Super. at 68, 502 A.2d at 1278; *see also* 1982 PRESIDENT'S COMMISSION REPORT, *supra,* at 179. Most people do not foresee what calamities may befall them; much less do they consider, or even think about, treatment alternatives in varying situations. The court in a substituted judgment case, therefore, should pay special attention to the known values and goals of the incapacitated patient, and should strive, if possible, to extrapolate from those values and goals what the patient's decision would be.

Although treating physicians may be an invaluable source of such information about a patient, the family will often be the best source. *See, e.g., In re Jobes, supra,* 108 N.J. at 408, 529 A.2d at 445–446. Family members or other loved ones will usually be in the best position to say what the patient would do if competent. [19] The court should be mindful, however, that while in the majority of cases family members will have the best interests of the patient in mind, sometimes family members will rely on their own judgments or predilections rather than serving as conduits for expressing the patient's wishes. This is why the court should endeavor, whenever possible, to make an in-person appraisal "of the patient's personal desires and ability for rational choice. In this way the court can always know, to the extent possible, that the judgment is that of the individual concerned and not that of those who believe, however well-intentioned, that they speak for the person whose life is in the balance." *In re Osborne, supra,* 294 A.2d at 374; *see also John F. Kennedy Memorial Hospital, Inc. v. Bludworth, supra,* 452 So.2d at 926–927 ("Disagreement among the physicians ***1251** or family members or evidence of wrongful motives or malpractice may require judicial intervention"). [20]

In short, to determine the subjective desires of the patient, the court must consider the totality of the evidence, focusing particularly on written or oral directions concerning treatment to family, friends, and health-care professionals. The court should also take into account the patient's past decisions regarding medical treatment, and attempt to ascertain from what is known about the patient's value system, goals, and desires what the patient would decide if competent. *See In re Conroy, supra,* 98 N.J. at 343–44, 486 A.2d at 1229–1230; *In re Dorone, supra,* 349 Pa.Super. at 68, 502 A.2d at 1278.

After considering the patient's prior statements, if any, the previous medical decisions of the patient, and the values held by the patient, the court may still be unsure what course the patient would choose. In such circumstances the court may supplement its knowledge about the patient by determining what most persons would likely do in a similar situation. *In re Boyd, supra,* 403 A.2d at 751, citing *Saikewicz, supra,* 373 Mass. at 343, 370 N.E.2d at 430; *accord,* 1983 PRESIDENT'S COMMISSION REPORT, *supra,* at 135; 1982 PRESIDENT'S COMMISSION REPORT, *supra,* at 180–181. When the patient is pregnant, however, she may not be concerned exclusively with her own welfare. [21] Thus it is proper for the court, in a case such as this, to weigh (along with all the other factors) the mother's prognosis, the viability of the fetus, the probable result of treatment or non-treatment for both mother and fetus, and the mother's likely interest in avoiding impairment for her child together with her own instincts for survival. *Cf. In re Roe, supra,* 383 Mass. at 431, 421 N.E.2d at 57.

Additionally, the court should consider the context in which prior declarations, treatment decisions, and expressions of personal values were made, including whether statements were made casually or after contemplation, or in accordance with deeply held beliefs. *See In re Conroy, supra,* 98 N.J. at 344, 486 A.2d at 1230; *In re Dorone, supra,* 349 Pa.Super. at 68, 502 A.2d at 1278; *In re Colyer, supra,* 99 Wash.2d at 125, 660 P.2d at 748. Finally, in making a substituted judgment, the court should become as informed about the patient's condition, prognosis, and treatment options as one would expect any patient to become before making a treatment decision. *See In re Conroy, supra,* 98 N.J. at 345, 486 A.2d at 1231. Obviously, the weight accorded to all of these factors will vary from case to case.

C. The Trial Court's Ruling

We reiterate that we cannot find the facts in this or any other case. That is the function of trial judges, who can view the witnesses and discern from their demeanor and testimony, rather than a cold written record, what the facts are. In this case there is an understandable paucity of factual findings, which necessarily limits our review. The trial court, faced with an issue affecting life and death, was forced to make a decision with almost no time for deliberation. Nevertheless, after reviewing the transcript of the hearing and the court's oral findings, it is clear to us that the trial court did not follow the substituted judgment procedure. On the contrary, the court's specific finding before its decision was communicated to A.C. was as follows:

> ***1252** The court is of the view that it does not clearly know what [A.C.'s] present views are with respect to the issue of whether or not the child should live or die. She's presently unconscious. As late as Friday of last week, she wanted the baby to live. As late as yesterday, she did not know for sure.

The court did not go on, as it should have done, to make a finding as to what A.C. would have chosen to do if she were competent. Instead, the court undertook to balance the state's and L.M.C.'s interests in surgical intervention against A.C.'s perceived interest in not having the caesarean performed.

After A.C. was informed of the court's decision, she consented to the caesarean; moments later, however, she withdrew her consent. The trial court did not then make a finding as to whether A.C. was competent to make the medical decision or whether she had made an informed decision one way or the other. Nor did the court then make a substituted judgment for A.C. Instead, the court said that it was "still not clear what her intent is" and again ordered the caesarean.

It is that order which we must now set aside. What a trial court must do in a case such as this is to determine, if possible, whether the patient is capable of making an informed decision about the course of her medical treatment. If she is, and if she makes such a decision, her wishes will control in virtually all

cases. If the court finds that the patient is incapable of making an informed consent (and thus incompetent), then the court must make a substituted judgment. This means that the court must ascertain as best it can what the patient would do if faced with the particular treatment question. Again, in virtually all cases the decision of the patient, albeit discerned through the mechanism of substituted judgment, will control. We do not quite foreclose the possibility that a conflicting state interest may be so compelling that the patient's wishes must yield, [22] but we anticipate that such cases will be extremely rare and truly exceptional. This is not such a case.

Having said that, we go no further. We need not decide whether, or in what circumstances, the state's interests can ever prevail over the interests of a pregnant patient. We emphasize, nevertheless, that it would be an extraordinary case indeed in which a court might ever be justified in overriding the patient's wishes and authorizing a major surgical procedure such as a caesarean section. Throughout this opinion we have stressed that the patient's wishes, once they are ascertained, must be followed in "virtually all cases," *ante* at 1249, unless there are "truly extraordinary or compelling reasons to override them," *ante* at 1247. Indeed, some may doubt that there could ever be a situation extraordinary or compelling enough to justify a massive intrusion into a person's body, such as a caesarean section, against that person's will. Whether such a situation may someday present itself is a question that we need not strive to answer here. We see no need to reach out and decide an issue that is not presented on the record before us; this case is difficult enough as it is. We think it sufficient for now to chart the course for future cases resembling this one, and to express the hope that we shall not be presented with a case in the foreseeable future that requires us to sail off the chart into the unknown. [23]

***1253** V

Ordinarily, when the factual record in a case is insufficient to support the trial court's decision, we remand for additional findings. In this case, however, a remand for supplemental findings would be inappropriate and futile because the caesarean has been performed and cannot be undone. The record is unclear as to whether A.C. was ever competent, after being sedated, to make her own decision, and the likelihood of marshaling further evidence now on this question is doubtful at best. If the substituted judgment procedure were to be followed, there is evidence going both ways as to what decision A.C. would have made, and we see no point in requiring the court now to make that determination when it can have no practical effect on either A.C. or L.M.C.

Accordingly, we vacate the order of the trial court and remand the case for such further proceedings as may be appropriate. We note, in doing so, that the trial court's order allowing the hospital to perform the caesarean section was presumptively valid from the date it was entered until today. What the legal effect of that order may have been during its lifetime is a matter on which we express no opinion here.

Vacated and remanded.

BELSON, Associate Judge, concurring in part and dissenting in part:

I agree with much of the majority opinion, but I disagree with its ultimate ruling that the trial court's order must be set aside, and with the narrow view it takes of the state's interest in preserving life and the unborn child's interest in life.

More specifically, I agree with the guidance the opinion affords trial judges as to how to approach a case like this, first determining the mother's competency to make an informed decision whether to have a caesarean delivery and, if the mother is not competent, then making a substituted judgment for the mother. I also agree that, with respect to surgical procedures, the pregnant woman's wishes, either as stated expressly or as discerned through substituted judgment, should ordinarily be respected and carried out unless there are compelling reasons to override them.

I disagree, however, with the majority's holding, opinion at 1252, that the trial judge erred in failing to determine competency. I think it quite clear from the record that Judge Sullivan found A.C. incompetent. The court heard testimony that A.C. was "heavily sedated" and that there could be no "meaningful conversation with her at this point," and that any reduction of her medication to "permit recovery of enough cognitive function on her part" to enable the physicians to get a sense of her preference regarding therapy might have the effect of hastening her death. Given the testimony that A.C. was unable to communicate her attitude toward the proposed surgery, if she had one, I submit that the most reasonable reading of the record is that the judge found her incompetent when he stated: "The Court is of the view that it does not clearly know what [A.C.'s] present views are with respect to the issue of whether or not the child should live

or die." A short time later, after hearing testimony about the sedated A.C.'s apparent reaction to the court's decision regarding surgery, the trial judge said: "The Court is still not clear what her intent is." I think the most reasonable reading of the judge's findings made under emergency circumstances remains that A.C. was found not competent either to arrive at or to communicate an informed decision about the proposed procedure. It is clear that the trial judge, at the very least, made a finding that was, under the majority's explanation of appropriate procedures, sufficient to move the inquiry forward to the substituted judgment stage.

I disagree also with the holding that the trial judge committed reversible error in failing to make a determination of substituted judgment. No party explicitly asked that he should do so, and the majority ***1254** acknowledges that it could find no reported opinion applying the substituted judgment procedure to the case of an incompetent pregnant patient in A.C.'s situation. Majority opinion at 1249. Under the circumstances, the trial judge's failure to exercise substituted judgment *sua sponte* can hardly be deemed the sort of egregious error that must be present before a trial court can be reversed on a plain error standard. *See Woodard v. City Stores Co.,* 334 A.2d 189, 192 (D.C.1975).

For the same reason, I disagree with the holding of the majority that Judge Sullivan erred in proceeding to a balancing analysis, weighing the rights of A.C. against those of the state and the unborn child without first having found either a competent refusal or a finding of nonconsent through substituted judgment. Majority opinion at 1247. No party argued that the court should not proceed to such a balancing analysis.[1] Because I disagree with this pivotal finding of error, I would affirm rather than reverse.

Another aspect of the majority opinion deserves comment. Having determined that the trial court must be reversed, the majority goes on to opine, in dictum, that this particular case is not one of those "extremely rare and truly exceptional" cases in which a patient's wishes regarding the proposed medical treatment can be overruled by reason of a compelling state interest (here, the interest in protecting the life of the viable unborn child). This is dictum because, as the majority points out, "[w]e have no reason to believe that, if competent, A.C. would or would not have refused consent to a caesarean."[2] Majority opinion at 1247. That being the case, and the actual application of the standard the majority adopts to the facts of this case not being necessary to the majority's determination to reverse, one must regard as dictum the majority's statement that this would not be one of those rare cases in which compelling interests might warrant overriding a mother's decision not to consent.

I think it appropriate, nevertheless, to state my disagreement with the very limited view the majority opinion takes of the circumstances in which the interests of a viable unborn child can afford such compelling reasons. The state's interest in preserving human life and the viable unborn child's interest in survival are entitled, I think, to more weight than I find them assigned by the majority when it states that "in virtually all cases the decision of the patient ... will control." Majority opinion at 1252. I would hold that in those instances, fortunately rare, in which the viable unborn child's interest in living and the state's parallel interest in protecting human life come into conflict with the mother's decision to forgo a procedure such as a caesarean section, a balancing should be struck in which the unborn child's and the state's interests are entitled to substantial weight.

It was acknowledged in *Roe v. Wade,* 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973), that the state's interest in potential human life becomes compelling at the point of viability. Even before viability, the state has an "important and legitimate interest in protecting the potentiality of human life." *Id.* at 162, 93 S.Ct. at 731. When approximately the third trimester of pregnancy is reached (roughly the time of viability, although with advances in medical science the time of viability is being reached sooner and sooner), the state's interest becomes sufficiently compelling to justify what otherwise would be unduly burdensome state interference with the woman's constitutionally protected privacy interest. *Beal v. Doe,* 432 U.S. 438, 446, 97 S.Ct. 2366, 2371, 53 L.Ed.2d 464 (1977). Once that stage is reached, the state "may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation ***1255** of the life or health of the mother." *Roe, supra,* 410 U.S. at 165, 93 S.Ct. at 732. In addressing this issue, it is important to emphasize, as does the majority opinion, that this case is not about abortion, majority opinion at 1245 n. 9;[3] we are not discussing whether a woman has the legal right to terminate her pregnancy in its early stages. Rather, we are dealing with the situation that exists when a woman has carried an unborn child to viability. When the unborn child reaches the state of viability, the child becomes a party whose interests must be considered. *See* King, *The Juridical Status of the Fetus: A Proposal for Legal Protection of the Unborn,* 77 MICH.L.REV. 1647, 1687 (1979) (viability, not birth, the determinative moment in

development for purpose of determining when fetus is entitled to legal protection).

Turning to the rights of the child, tort law has long recognized the right of a living child to recover for injuries suffered when she was a viable unborn child. *See Bonbrest v. Kotz,* 65 F.Supp. 138 (D.D.C.1946). In rejecting the notion that the viable unborn child is not an entity distinct from the mother, the court in *Bonbrest* stated:

> It has, if viable, its own bodily form and members, manifests all the anatomical characteristics of individuality, possesses its own circulatory, vascular and excretory systems and is capable *now* of being ushered into the visible world.

Id. at 141 (footnote omitted).

Bonbrest proved to be a landmark case. In *Greater Southeast Hospital v. Williams,* 482 A.2d 394 (D.C.1984), this court noted that "every jurisdiction in the United States has followed *Bonbrest* in recognizing a cause of action for prenatal injury, at least when the injury is to a viable infant later born alive." *Id.* at 396. We went on to hold in *Greater Southeast Hospital* that a viable unborn child *is a person* within the coverage of the wrongful death statute, D.C.Code § 16–2701 (1981):

> Inherent in our adoption of *Bonbrest* is the recognition that a viable fetus is an independent person with the right to be free of prenatal injury. The liability for prenatal injury recognized in *Bonbrest* arises at the time of the injury. If a viable fetus is a "person injured" at the time of the injury, then perforce the fetus is a "person" when he dies of those injuries, and it can make no difference in liability under the wrongful death and survival statutes whether the fetus dies of the injuries just prior to or just after birth. To hold otherwise would perpetuate the very evils the statutes were intended to prevent—that an injury would be inflicted for which no remedy existed and a tortfeasor would escape liability by inflicting injury so severe that death results.

Id. at 397.

We concluded: "In summary, having determined that a *viable fetus is a person under the common law,* it follows that injury to the fetus resulting in death is actionable under our wrongful death and survival statutes." *Id.* at 398 (emphasis added).

The holdings in *Bonbrest* and *Greater Southeast Hospital* establish that for purposes that are, at least, relevant to this case, a viable unborn child is a *person* at common law who has legal rights that are entitled to the protection of the courts. In a case like the one before us, the unborn child is a patient of both the hospital and any treating physician, [4] and the hospital or physician may be liable to the child for the child's prenatal injury or death if caused by ***1256** their negligence. *See Greater Southeast Hospital, supra; Bonbrest, supra.*

Without going into the difficult question of the extent to which an unborn viable child may be entitled to protection under the Fifth, the Fourteenth, or other Amendments to the Constitution, [5] the already recognized rights and interests mentioned above are sufficient to indicate the need for a balancing process in which the rights of the viable unborn child are assigned substantial weight. This view is consistent with the decision of the only appellate court which has heretofore considered this issue. In *Jefferson v. Griffin Spalding County Hosp. Auth.,* 247 Ga. 86, 274 S.E.2d 457 (1981), the Supreme Court of Georgia denied a stay of an order authorizing a hospital to perform a caesarean section to which the mother did not consent. Concurring, Presiding Justice Hill described the way in which the outcome was reached in the following language:

> In denying the stay of the trial court's order and thereby clearing the way for immediate re-examination by sonogram and probably for surgery, we weighed the right of the mother to practice her religion and to refuse surgery on herself, against her unborn

> child's right to live. We found in favor of her child's right to live.

Id. 274 S.E.2d at 460. [6]

The balancing test should be applied in instances in which women become pregnant and carry an unborn child to the point of viability. This is not an unreasonable classification because, I submit, a woman who carries a child to viability is in fact a member of a unique category of persons. Her circumstances differ fundamentally from those of other potential patients for medical procedures that will aid another person, for example, a potential donor of bone marrow for transplant. This is so because she has undertaken to bear another human being, and has carried an unborn child to viability. Another unique feature of the situation we address arises from the singular nature of the dependency of the unborn child upon the mother. A woman carrying a viable unborn child is not in the same category as a relative, friend, or stranger called upon to donate bone marrow or an organ for transplant. Rather, the expectant mother has placed herself in a special class of persons who are bringing another person into existence, and upon whom that other person's life is totally dependent. Also, uniquely, the viable unborn child is literally captive within the mother's body. No other potential beneficiary of a surgical procedure on another is in that position.

For all of these reasons, a balancing becomes appropriate in those few cases where the interests we are discussing come into conflict. To so state is in no sense to fail to recognize the extremely strong interest of each individual person, including of course the expectant mother, in her bodily integrity, her privacy, and, where involved, her religious beliefs.

Thus, I cannot agree with the conclusion of the majority opinion that while we "do not quite foreclose the possibility that a ***1257** conflicting state interest may be so compelling that the patient's wishes must yield ... we anticipate that such cases will be extremely rare and truly exceptional." Majority opinion at 1252. While it is, fortunately, true that such cases will be rare in the sense that such conflicts between mother and viable unborn child are rare, [7] I cannot agree that in cases where a viable unborn child is in the picture, it would be extremely rare, within that universe, to require that the mother accede to the vital needs of the viable unborn child. [8]

I turn now to the impact of this decision on future cases in this jurisdiction. Despite the majority's admonition that "nothing in this opinion should be read as either approving or disapproving the holding in *In re Madyun,* " 114 Daily Wash.L.Rptr. 2233 (D.C.Super.Ct. July 26, 1986), majority opinion at 1252–1253 n. 23, I am concerned that the majority's emphasis on the "extremely rare and truly exceptional" nature of the circumstances in which the unborn child's rights may prevail may move the law toward the extinguishment of the rights of unborn children in cases like *In re Madyun.* In that case, the trial court was faced with a situation in which an expectant mother refused on religious grounds to consent to a caesarean section even though she was already in labor, and sixty hours had passed since her membrane had ruptured. Although the heavy risks of infection and possible death to the fetus in the absence of a caesarean section were explained to both parents, they refused to consent to the caesarean section. Because the child could not be delivered through the birth canal, the child faced a serious and increasing danger of death or brain damage, and the mother's health was endangered as well.

After considering the facts and applicable law, the Superior Court granted the hospital's request for authorization to deliver the baby by the most expedient means—a caesarean section. [9] Counsel appointed to represent the unborn child had also joined the hospital's request. A motions division of this court denied a stay of the trial court's order. Pursuant to the trial court's order, the caesarean section was performed, and a healthy child was born and survives. [10]

I next address the sensitive question of how to balance the competing rights and interests of the viable unborn child and the state against those of the rare expectant mother who elects not to have a caesarean section necessary to save the life of her child. [11] The indisputable view that a woman carrying a viable child has an extremely strong interest in her own life, health, bodily integrity, privacy, and religious beliefs necessarily requires that her election be ***1258** given correspondingly great weight in the balancing process. In a case, however, where the court in an exercise of a substituted judgment has concluded that the patient would probably opt against a caesarean section, the court should vary the weight to be given this factor in proportion to the confidence the court has in the accuracy of its conclusion. Thus, in a case where the indicia of the incompetent patient's judgment are equivocal, the court should accord this factor correspondingly less weight. The appropriate weight to be given other factors will have to be worked out by the development of law in

this area, and cannot be prescribed in a single court opinion. Some considerations obviously merit special attention in the balancing process. One such consideration is any danger to the mother's life or health, physical or mental, including the relatively small but still significant danger that necessarily inheres in any caesarean delivery, and including especially any danger that exceeds that level. [12] The mother's religious beliefs as they relate to the operation would appear to deserve inclusion in the balancing process.

On the other side of the analysis, it is appropriate to look to the relative likelihood of the unborn child's survival. This could range from the situation in *Madyun* where the full-term child's chances for survival were apparently excellent, through a case like the one before us where the unborn child's chances for survival were from fifty to sixty percent, and on to cases where the child's chances for survival are less than even. The child's interest in being born with as little impairment as possible should also be considered. [13] This may weigh in favor of a delivery sooner rather than later. The most important factor on this side of the scale, however, is life itself, because the viable unborn child that dies because of the mother's refusal to have a caesarean delivery is deprived, entirely and irrevocably, of the life on which the child was about to embark.

Turning to the specifics of this case, and reaching them as I, unlike the majority, must because of my view that the court did not commit plain error in bypassing substituted judgment and performing a balancing test, I think this court cannot on this record hold that the trial judge abused his discretion in striking the balance he did.

Weighed in the balance against ordering the procedure were two considerations that were central to the entire proceeding: the invasive and serious nature of the proposed surgery and the fact that such surgery cannot ordinarily be performed without the consent of the patient. Under the peculiar circumstances of this case, the influence of these factors was diminished by the fact that it was not clear whether A.C. would have consented to the surgery or not. Before events began to close in on her, A.C. had agreed to a caesarean at twenty-eight weeks. Thus, she was not averse, in principle, to having that particular type of surgery. What was unresolved was whether she would consent to that surgery at twenty-six and one-half weeks, when the unborn child's chances of survival were somewhat reduced and the chances of impairment to the child somewhat enhanced. It was clear that she had intended all along to carry her unborn child until the point the child could be successfully delivered, and she persevered in that intention even when she knew she would not live long, if at all, after her child was born. Even in the tragically difficult circumstances in which A.C. found herself at the very time of the court's proceedings, she first appeared in her sedated state to agree to the procedure and then apparently to disagree. Under the circumstances, the court could deem these ***1259** matters, usually most pertinent to a determination of substituted judgment, to lessen the net weight of the factors that weighed against the performance of the surgery. [14] Also to be considered in the balance was the rather minimal, but nevertheless undisputable, additional risk that caesarean delivery presented for the mother. [15]

Turning to the interest of the unborn child in living and the parallel interest of the state in protecting that life, the evidence indicated that the child had a fifty to sixty percent chance of survival and a less than twenty percent chance of entering life with a serious handicap such as cerebral palsy or mental retardation. The evidence also showed that a delay in delivering the child would have increased the likelihood of a handicap. In view of the record before Judge Sullivan, and on the basis that there had been no plain error in not applying the sort of substituted judgment analysis that we for the first time mandate in today's ruling, I think it cannot be said that he abused his discretion in the way he struck the balance between the considerations that favored the procedure and those that went against it. [16]

For the reasons stated above, I would affirm.

APPENDIX

SUPERIOR COURT OF THE DISTRICT
OF COLUMBIA CIVIL DIVISION

IN RE MADYUN

Misc. No. 189–86

Diane Weinroth for parents.

Martin R. Baach for fetus.

Richard S. Love, Assistant Corporation Counsel, for the District of Columbia.

LEVIE, *Associate Judge* :

Upon the oral petition of D.C. General Hospital ("Hospital") for an order that the Hospital be authorized to perform a Caesarean section upon Ayesha Madyun to deliver her fetus, a hearing was convened at the Hospital at 10:30 p.m. on July 25, 1986. Diane Weinroth, Esq., accepted appointment by the Court to represent the parents, Yahya and Ayesha Madyun; Martin R. Baach, Esq., accepted appointment by the Court to be *guardian ad litem* for the fetus; and Assistant Corporation Counsel Richard S. Love represented the Hospital. ***1260** Testimony was taken from Dr. John Cummings, Chief Resident on the Georgetown University Obstetrical/Gynecological service, as well as from Mr. and Mrs. Madyun. After hearing testimony and arguments of counsel, the Court orally granted the Hospital's petition at 1:05 a.m., on July 26 and then denied the parents' motion for a stay. [1] A telephonic appeal was heard and the decision of this Court was affirmed (Pryor, C.J. and Terry, J.). [2]

FINDINGS OF FACT

The mother of the infant, Ayesha Madyun, is a 19–year–old woman experiencing her first pregnancy. She arrived at the Hospital on July 25, 1986, at approximately 1:45 a.m., after previously having been to Greater Southeast Community Hospital for an unknown period of time. Upon admission to the Hospital, it was determined that she was at term; she related that her membrane had ruptured (water broken) some 48 hours earlier. [3] Mrs. Madyun indicated throughout the entire time prior to the performance of the Caesarean section that she wanted a natural delivery. By 11:00 a.m. on July 25 she was seven centimeters dilated. When the hearing convened at the Hospital almost 12 hours later, Mrs. Madyun was still dilated at seven centimeters. By the time of the hearing her contractions were coming at intervals approximately five minutes apart. [4]

Mr. and Mrs. Madyun met with the medical staff at approximately 4:00 p.m. and again at 8:00 p.m. on July 25 to discuss the available options. When no progress toward completing a natural (vaginal) delivery was evidenced by 8:00 p.m., it was recommended that Mrs. Madyun consent to undergo Caesarean section to deliver the fetus. Consent to perform a Caesarean section was denied. When questioned during the hearing, some four hours after the 8:00 p.m. conference, Mrs. Madyun reiterated her preference for a natural delivery and expressed her belief that a Caesarean section was not necessary. She understood the risks of infection to the fetus resulting from continuation of labor without delivery, but sought to explain her decision to decline a Caesarean section by reference to her religious beliefs. Mrs. Madyun testified that a Muslim woman has the right to decide whether or not to risk her own health to eliminate a possible risk to the life of her undelivered fetus. [5]

During a separate, longer interview, Mr. Madyun explained that his refusal to consent to the performance of a Caesarean was based upon his belief that there was no demonstrable danger at that point to either Mrs. Madyun or the fetus. [6] For example, Mr. Madyun stated that there were no signs of the onset of sepsis except a slightly elevated temperature. Further, it was his belief that there had been insufficient opportunity for his wife to deliver vaginally. He also expressed his view that the Hospital had failed to permit Mrs. Madyun to engage in certain potentially natural acts of assisting delivery, such as standing up or walking around. Mr. Madyun similarly explained that a Muslim woman, confronted with a life or death situation, had the right to decide whether to risk her health or life to save an unborn fetus. The risks of infection and possible death to the fetus in the absence of a Caesarean section were likewise explained to and understood by Mr. Madyun.

***1261** The medical basis for the Hospital's emergency oral petition was presented through the testimony of Dr. Cummings. After receiving his M.D. degree at the George Washington University, Dr. Cummings took a two-year general surgery program at Emory University. This was followed by a four-year period as a physician in the U.S. Navy Medical Corps. He is now in the final year of a four-year obstetrical/gynecological program at Georgetown, and is Chief Resident of the Georgetown Service at the Hospital.

According to Dr. Cummings, normal labor for an uncomplicated first pregnancy is 10–15 hours. For a woman in her first pregnancy to remain dilated at seven centimeters for 12 hours was, in his opinion, abnormal. [7] Normal obstetrical procedures with a term pregnancy call for delivery of a baby within 24 hours of the membrane's rupture.

Failure to adhere to this procedure increases the risk of chorioamnionitis (inflammation of the fetal placental membranes) which can lead to fetal sepsis (infection). This, in turn, can result in the death of the baby or brain damage. Sepsis can start at any time 24 hours after rupture of the

membrane. The likelihood of infection to the baby (fetus) increases greatly in proportion to the length of time between rupture of the membrane and delivery of the baby. It was the opinion of Dr. Cummings that each passing hour increased the risk of fetal sepsis.

As Dr. Cummings explained, one of the most insidious dangers in the situation presented by Mrs. Madyun was that sepsis could begin without detection and advance to the point of causing the death of the baby with little, or possibly no, warning. Prior to birth, it is difficult to determine the commencement of fetal sepsis. While there are certain symptoms of fetal sepsis (maternal temperature, foul smelling discharge, and fetal heartbeat), evidence of them may not become apparent until the baby is already septic. [8] Given the fact that, by the time of hearing, Mrs. Madyun's membrane had ruptured between 60 and 70 hours earlier, Dr. Cummings believed that the risk of fetal sepsis here was 50–75%. [9] In contrast, the risk to Mrs. Madyun undergoing a Caesarean section was said to be 0.25%.

Against this background, the Hospital was seeking authorization to deliver the baby by the most expedient means —a Caesarean section. [10] On behalf of the unborn child, Mr. Baach joined in the Hospital's request that authorization for the Caesarean section be granted.

CONCLUSIONS OF LAW

When a competent adult declines medical treatment on religious grounds, the Court is obligated to respect this decision, even in a life or death situation, unless the state can "demonstrate a compelling interest that would justify overriding the individual's choice." *In re Lucille Boyd,* 403 A.2d 744, 748 (D.C.1979); *In re Osborne,* 294 A.2d 372, 374 (D.C.1972); *Canterbury v. Spence,* 150 U.S. App.D.C. 263, 271, 464 F.2d 772, 780, *cert. denied,* 409 U.S. 1064, [93 S.Ct. 560, 34 L.Ed.2d 518] (1972); *In the Matter of B.B.H.,* 111 Wash.L.Rep. 1929, 1934 (D.C.Super.Ct., Oct. 6, 1983) (Schwelb, J.); *In the Matter of Bentley,* 102 Wash.L.Rep. 1221, 1225 (D.C.Super.Ct., June 17, 1974) (Burka, J.); *John F. Kennedy Memorial Hospital v. Heston,* 58 N.J. 576, 279 A.2d 670, 674 (1971); cf. ***1262** *Application of the President and Directors of Georgetown College, Inc.,* 118 U.S.App.D.C. 80, 331 F.2d 1000 (1964).

In the case of children, the state acting as *parens patriae* has the ability, in appropriate situations, to "restrict" a parent's control of a child, even where the parent's claim to control is founded upon religious rights or a more generalized "right[ ] of parenthood...." *Prince v. Massachusetts,* 321 U.S. 158, 166 [64 S.Ct. 438, 442, 88 L.Ed. 645] (1944). Thus, where the requisite factual predicate has been established, courts have ordered medical treatment of children over parental objections. *See e.g., In the Matter of B.B.H.,* 111 Wash.L.Rep.1929 (Four hour old infant); *In the Matter of Adam L.,* 111 Wash.L.Rep. 25 (D.C.Super.Ct., Jan. 6, 1983) (Schwelb, J.) (2 year old); *Custody of a Minor,* 375 Mass. 733, 379 N.E.2d 1053 (1978) (26 month old infant); *In the Matter of Kevin Sampson,* 37 A.D.2d 668, 323 N.Y.S.2d 253 (1971) (16 year old). With both children and adults, therefore, the question of the state's "compelling interest" is a crucial factor to be determined.

Counsel for the parents, while not challenging these general propositions of law, questioned whether consideration of the state's interest affecting a child already born applies with the same force to an unborn child. Under the facts here, the answer is yes.

The state has an "important and legitimate interest in protecting the potentiality of human life." *Roe v. Wade,* 410 U.S. 113, 162 [93 S.Ct. 705, 731, 35 L.Ed.2d 147] (1973). At the point of "viability" [11] the state's interest becomes " 'compelling' " *id.* at 163. To be sure, by the third trimester the state's intent "become[s] sufficiently compelling to justify unduly burdensome state interference with the woman's constitutionally protected privacy interest." *Beal v. Doe,* 432 U.S. 438, 446 [97 S.Ct. 2366, 2371, 53 L.Ed.2d 464] (1977). A "compelling interest" of the state may likewise justify overriding religious convictions in cases of unborn infants. *In re Osborne,* 294 A.2d at 374; *Jefferson v. Griffin Spalding County Hospital Authority,* 247 Ga. 86, 274 S.E.2d 457 (1981) (*per curiam*) (unborn infant); *Raleigh Fitkin–Paul Morgan Memorial Hospital v. Anderson,* 42 N.J. 421, 201 A.2d 537 (*per curiam*), *cert. denied,* 377 U.S. 985 [84 S.Ct. 1894, 12 L.Ed.2d 1032] (1964) (unborn infant); *In the Matter of Application of Jamaica Hospital,* 128 Misc.2d 1006, 491 N.Y.S.2d 898 (Sup.Ct.1985) (unborn infant).

Because Mrs. Madyun was at term, there was no issue as to viability. All that stood between the Madyun fetus and its independent existence, separate from its mother, was, put simply, a doctor's scalpel. In these circumstances, the life of the infant inside its mother's womb was entitled to be

protected. *See e.g., Jefferson v. Griffin Spalding,* 274 S.E.2d at 460; *Raleigh Fitkin–Paul Morgan Mem. Hosp. v. Anderson,* 201 A.2d at 538; *In re Appl. of Jamaica Hosp.,* 491 N.Y.S.2d at 989–900.

In *Jefferson v. Griffin Spalding County Hosp. Auth.,* 247 Ga. 86, 274 S.E.2d 457 (1981) the Georgia Supreme Court denied a request for a stay of an order of the Superior Court that a mother submit to a Caesarean section. There, the mother who was at term had a condition which made it "a 95% certainty that the child cannot survive natural childbirth (vaginal delivery)." *Id.* [274 S.E.2d] at 458. Indeed, the mother's chances of surviving a vaginal delivery were only 50%. *Id.* Asserting religious beliefs, the mother refused to submit to the C-section or to any blood transfusion. *Id.* The trial court, however, found " 'that the state has an interest in the life of this unborn, living human being. The Court finds that the intrusion into the life of [the parents] is outweighed by the duty of the state to protect a living, unborn human being from meeting his or her death before being given the opportunity to live.' " *Id.* at 460. The Georgia Supreme Court denied the parents' request for a stay. *Id.* [12]

***1263** In the instant case, the Court was confronted with a 50–75% risk of infection for the infant, in view of the extended period of time (60 hours) since rupture of the mother's membrane. The testimony adduced at the hearing was that the onset of infection to the infant could begin and progress to a potentially fatal point before symptoms of the infection became evident. To have required the doctors to continue a "wait and see" attitude could have had potentially fatal consequences to the infant. It is one thing for an adult to gamble with nature regarding his or her own life; it is quite another when the gamble involves the life or death of an unborn infant.

The Court had before it parents who, in part, refused a Caesarean section on the basis of religious beliefs. Although both parents impressed the Court as sincere, it was evident that the stronger basis for their individual decisions was the belief that the surgical procedure was not necessary and that additional steps could be taken to enhance the possibility of a vaginal delivery. Neither parent, however, is a trained physician. To ignore the undisputed opinion of a skilled and trained physician to indulge the desires of the parents where, as here, there is a substantial risk to the unborn infant, is something the Court cannot do. [13] Indeed, even if the religious beliefs of the parents were the primary or sole reason for refusing a Caesarean, the state had a compelling interest in ensuring this infant could be born. *See Jefferson v. Griffin Spalding,* 274 S.E.2d at 460. "Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves." *Prince v. Massachusetts,* 321 U.S. at 170 [64 S.Ct. at 444]. On these facts, the parents may not make a martyr of their unborn infant.

Accordingly, the Hospital is ordered to take such steps as medically indicated, including but not limited to a C-section, to preserve and protect the birth and safety of the fetus.

Interim Findings and Conclusions

Upon petition of D.C. General Hospital for an order that the Hospital be authorized to perform a Caesarean section upon Ayesha Madyun (mother) to deliver her fetus and having heard from Mr. and Mrs. Madyun, counsel for the Hospital, the parents, the guardian *ad litem* and Dr. Cummings:

The Court finds that Mrs. Madyun's membrane ruptured at noon on July 23, 1986 and has been so far more than 60 hours; for almost 12 hours she has remained dilated at 7 cm.; that Dr. Cummings has given his medical opinion the fetus is at risk of fetal sepsis (infection) if a C-section is not performed at once [and that], the risk of sepsis increases. By contrast the risk to the mother of a C-section is at .25%. The basis for the parents' objection is a religious belief that, as Muslims, it is the choice of the mother to decide between her health and body and that of the fetus. Dr. Cummings said that normal medical practice calls for delivery of a baby within 24 hours of the rupture of the membrane. ***1264** There is no way to determine whether sepsis has or will begin and it can begin and progress to such a stage that death could be imminent. Mrs. Madyun's labor pattern is aberrant according to Dr. Cummings. He also said the likelihood of infection is proportional to the time since the time of rupture and that sepsis can start any time after rupture. The risk of sepsis is between 50–75% under these conditions. No alternative medical procedures are available at this time; under the present circumstances, according to Dr. Cummings, sepsis can be fatal or lead to brain damage. Moreover, Dr. Cummings testified that there may be no signs of sepsis before it progresses to the point of causing death.

Given the significant risks to the fetus versus the minimal risks to the mother, the Court concludes that there is a

compelling interest to intervene and protect the life and safety of the fetus.

Accordingly, the Hospital is ordered to take such steps as are medically indicated, including but not limited to a C-section, to preserve and protect the birth and safety of the fetus.

The findings and conclusions are prepared for expeditiously facilitating a decision under the circumstances. The Court reserves the right to supplement these based upon the record and tape recordings. The parties can submit pleadings if they desire.

1:05 a.m. 7/26/86
Richard A. Levie

Associate Judge

Affirmed per Judges Pryor and Terry 2:08 a.m. 7/26/86

All Citations

573 A.2d 1235, 58 USLW 2644

Footnotes

* Judge Rogers was an Associate Judge of the court at the time of argument. Her status changed to Chief Judge on November 1, 1988.

** Judge Mack was an Associate Judge of the court at the time of argument. She was commissioned as a Senior Judge on December 1, 1989.

1 Strictly speaking, this is not a rehearing but an initial hearing en banc. The motions division heard only the application for a stay, which it denied and which is now moot. The en banc court, however, has before it the entire appeal on the merits, which no division of the court has ever considered.

2 We observe nevertheless that it would be far better if judges were not called to patients' bedsides and required to make quick decisions on issues of life and death. Because judgment in such a case involves complex medical and ethical issues as well as the application of legal principles, we would urge the establishment—through legislation or otherwise—of another tribunal to make these decisions, with limited opportunity for judicial review. *See Satz v. Perlmutter,* 379 So.2d 359, 360 (Fla.1980); *In re Conroy,* 98 N.J. 321, 335, 486 A.2d 1209, 1221 (1985); *In re Hamlin,* 102 Wash.2d 810, 817, 689 P.2d 1372, 1378–1379 (1984).

We also emphasize that our decision today is the result of considerable deliberation and that we have enjoyed two luxuries unavailable to the trial court: ample time to decide the case, and extensive briefs and oral argument from the parties and several *amici.* The trial judge had no such advantage. He was called in during the worst of emergencies, with little time for reflection, to make a decision which under the best of circumstances is extraordinarily difficult. Although we conclude that his decision must be set aside, we nevertheless commend him for the painstaking and conscientious manner in which he performed the task before him.

3 Dr. Edwards was testifying as an expert, but not as a treating physician. Up to that point she had had "no direct involvement" with either A.C. or her family, but she did hear the testimony of the treating physicians who were familiar with A.C.'s condition.

4 A.C.'s husband was too distraught to testify and uttered only a few words at the hearing.

5 *Madyun* was affirmed by this court in an unreported order. See also note 23, *infra.*

6 We do not revisit in this appeal the issue of whether this court is bound by the case-or-controversy strictures of Article III of the Constitution. *See Lee v. District of Columbia Board of Appeals & Review,* 423 A.2d 210, 216–217 n. 13 (D.C.1980); *Kopff v. District of Columbia Alcoholic Beverage Control Board,* 381 A.2d 1372, 1377–1378 & n. 11 (D.C.1977); D.C.Code § 11–705(b) (1989).

7 Because the patient in *Jefferson* had a placenta previa which blocked the birth canal, doctors estimated that without caesarean intervention there was a ninety-nine percent chance that her full-term fetus would perish and a fifty percent chance that the mother would die as well. The mother was unquestionably competent to make her own treatment decisions, but refused a caesarean because of her religious beliefs. A trial court gave custody of the fetus to state human resources officials and ordered a caesarean section; the Georgia Supreme Court denied the parents' motion for a stay.

8 There are also practical consequences to consider. What if A.C. had refused to comply with a court order that she submit to a caesarean? Under the circumstances, she obviously could not have been held in civil contempt and imprisoned or required to pay a daily fine until compliance. *Cf. United States v. United Mine Workers,* 330 U.S. 258, 304–306, 67 S.Ct.

677, 701–02, 91 L.Ed. 884 (1947); *D.D. v. M.T.,* 550 A.2d 37, 43 (D.C.1988). Enforcement could be accomplished only through physical force or its equivalent. A.C. would have to be fastened with restraints to the operating table, or perhaps involuntarily rendered unconscious by forcibly injecting her with an anesthetic, and then subjected to unwanted major surgery. Such actions would surely give one pause in a civilized society, especially when A.C. had done no wrong. *Cf. Rochin v. California,* 342 U.S. 165, 169, 72 S.Ct. 205, 208, 96 L.Ed. 183 (1952).

9 We think it appropriate here to reiterate and emphasize a point that the motions division made in its opinion: "that this case is not about abortion." *In re A.C., supra,* 533 A.2d at 614. Supreme Court decisions on abortion, beginning with *Roe v. Wade,* 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973), have been read as recognizing "a fundamental individual right to decide whether or not to beget or bear a child." *Bowers v. Hardwick,* 478 U.S. 186, 190, 106 S.Ct. 2841, 2844, 92 L.Ed.2d 140 (1986) (citation omitted). That decisional right is not at issue here, for the record makes clear that A.C. sought to become pregnant, that she wanted to bear her child as close to term as possible, and that neither she nor anyone associated with her at any time sought to terminate her pregnancy. The issue presented in this case is not whether A.C. (or any woman) should have a child but, rather, who should decide how that child should be delivered. That decision involves the right of A.C. (or any woman) to accept or forego medical treatment. The Supreme Court has not yet focused on this question in the context of a pregnancy, and we are not so adept at reading tea leaves as to predict how it might rule. *But see* Robertson, *Procreative Liberty, supra,* 69 VA.L.REV. at 451–452 (attempting such a prediction).

10 In the present case we are dealing with a caesarean section, which is plainly a major surgical procedure. Our discussion of the circumstances, if any, in which the patient's wishes may be overridden presupposes a major bodily invasion. We express no opinion with regard to the circumstances, if any, in which lesser invasions might be permitted, or where the line should be drawn between "major" and "minor" surgery.

11 Both *Hughes* and *Crowder* antedate the Supreme Court decision in *Winston v. Lee, supra.* We need not decide here whether *Winston* would require a different result if *Hughes* or *Crowder* were to arise today.

12 Courts have uniformly drawn a distinction between affirmatively acting to commit suicide and merely allowing one's body to follow its natural course without treatment. *E.g., In re Conroy, supra,* 98 N.J. at 337, 486 A.2d at 1224; *Saikewicz, supra,* 373 Mass. at 738 n. 11, 370 N.E.2d at 426 n. 11.

13 In this case no physician was ordered to perform surgery or to provide any treatment against his or her will. Further, the current ethical position of the medical community is that a physician treating a pregnant woman in effect has two patients, the mother and the fetus, and should assess the risks and benefits attendant to each in advising the mother on the course of her treatment. American College of Obstetricians and Gynecologists (ACOG) Ethics Committee Opinion No. 55; *Patient Choice: Maternal–Fetal Conflict* (October 1987).

14 We are not faced here with any legislative enactment in the area, and thus we have no occasion to rule in any respect on constitutional considerations, if any, that might affect statutory treatment of the various interests at issue.

15 We recognize, of course, that this will not always be feasible. Our expression of a preference for personal observation by a trial judge "whenever possible" should not be construed as a criticism of the trial judge in this case for failing to move the hearing to A.C.'s bedside.

16 In at least one case, a woman whose objection to a caesarean delivery had been overridden by a court went into hiding and gave birth to her child vaginally. *See* Rhoden, *supra,* 74 CAL.L.REV. at 1959–1960. In another case, "a 16–year–old pregnant girl in Wisconsin has been held in secure detention for the sake of her fetus because she tended to be on the run and to lack motivation or ability to seek prenatal care." *Obstetrical Interventions, supra,* 316 NEW ENG. J. MED. at 1195.

17 In an affidavit filed after the hearing, Dr. Moscow said that if he had been notified of the proceedings, he would have come to the hospital immediately and would have testified that a caesarean section was medically inadvisable *both for A.C. and for the fetus.* Dr. Moscow also viewed the hospital's handling of A.C.'s case as deficient in several other significant respects. In these circumstances we think it unfortunate that Dr. Moscow was not called by representatives of the hospital and made available to the court when the hospital decided to seek judicial guidance.

18 Although we appreciate the force of Judge Belson's plain error analysis, to which we would ordinarily be sympathetic, we think it somewhat harsh to preclude a party from making additional arguments on appeal in a case such as this, in which there was virtually no time to prepare for the hearing below.

19 Nevertheless, when a court is called upon to make a decision or to sanction one, it is frequently because there is a conflict as to treatment choice among family members, physicians, or both. Were family members and physicians in complete agreement, it is unlikely that a court would be brought into the discussion.

20 The family's primacy in aiding the court as surrogate decision-maker may be subject to challenge for a variety of reasons. For example, grieving family members may themselves be unable to make or communicate an informed decision. There may also be conflicting interests, or family members may be inclined for their own reasons to disregard what the patient

herself would want. *See* 1982 PRESIDENT'S COMMISSION REPORT, *supra,* at 183. On the other hand, we think it proper for the court to conclude that the patient might consider the needs of her family in making a treatment decision. *See In re Roe, supra,* 383 Mass. at 432, 421 N.E.2d at 58.

21 According to the ACOG Ethics Committee Opinion, *supra* note 13, "[t]he welfare of the fetus is of the utmost importance to the majority of women; thus only rarely will a conflict arise."

22 Absolutes like "never" should generally be avoided because "the future may bring scenarios which prudence counsels our not resolving anticipatorily." *Florida Star v. B.J.F.,* 491 U.S. 524, 109 S.Ct. 2603, 2608, 105 L.Ed.2d 443 (1989).

23 In particular, we stress that nothing in this opinion should be read as either approving or disapproving the holding in *In re Madyun, supra.* There are substantial factual differences between *Madyun* and the present case. In this case, for instance, the medical interests of the mother and the fetus were in sharp conflict; what was good for one would have been harmful to the other. In *Madyun,* however, there was no real conflict between the interests of mother and fetus; on the contrary, there was strong evidence that the proposed caesarean would be beneficial to both. Moreover, in *Madyun* the pregnancy was at full term, and Mrs. Madyun had been in labor for two and a half days; in this case, however, A.C. was barely two-thirds of the way through her pregnancy, and there were no signs of labor. If another *Madyun* -type case ever comes before this court, its result may well depend on facts that we cannot now foresee. For that reason (among others), we defer until another day any discussion of whether *Madyun* was rightly or wrongly decided.

1 In the telephone hearing before a division of this court that followed immediately after the trial judge's ruling, counsel for the mother acknowledged that balancing was appropriate.

2 In view of this statement, I find puzzling the majority's discussion at p. 1248, *et seq.,* of "two additional arguments against overriding A.C.'s objections to caesarean surgery." No such objections were found to exist.

3 The majority opinion, however, oversimplifies matters when it states, p. 1245 n. 9: "[T]he issue presented in this case is not whether A.C. (or any woman) should have a child but, rather, who should decide how that child should be delivered." The cruel realities of the situation made the issue far more difficult. It could better be stated as whether the unborn child should face a greatly reduced chance of survival upon *post mortem* delivery occasioned by a decision to forgo a caesarean procedure or whether, instead, the child should be afforded a probability of living as a result of a surgical procedure that involved both some risk to A.C. and an invasion of her bodily integrity.

4 J. Pritchard, P. MacDonald, & N. Gant, *Williams Obstetrics* 267 (17th ed. 1985).

5 I recognize that the Supreme Court has held that the word "person," as used in the Fourteenth Amendment, does not include the unborn. *Roe v. Wade, supra,* 410 U.S. at 158, 93 S.Ct. at 729. Nevertheless, this is a matter in which the policy of the law may evolve, and in the elastic frames of due process and equal protection analysis under the Fourteenth and Fifth Amendments, it may eventually be determined that viable unborn children are persons entitled, constitutionally, to protection of their liberty, their property, and their very lives, even though they may not be considered persons for some other purposes under the Constitution. Ultimately, the question of whether a viable unborn child is considered a person under the Fifth and Fourteenth or other Amendments to the Constitution for purposes of the right to survive is one of policy for the courts.

As one commentator has pointed out, however, the right of the viable unborn child to legal protection does not depend upon such classification as a person. King, *supra,* 77 MICH.L.REV. at 1687.

6 The majority opinion states that "*Jefferson* is of limited relevance, if any at all, to the present case." Majority opinion at 1243. I disagree. The Georgia courts balanced the interest of the unborn child in living against a competent mother's refusal to undergo a caesarean section, and ruled in favor of the child. That some of the circumstances were different from those in the case before us does not alter this most salient feature of the case.

7 The majority opinion at 1251 n. 21 quotes Opinion No. 55 of the Ethics Committee of the American College of Obstetricians and Gynecologists as follows: "[t]he welfare of the fetus is of the utmost importance to the majority of women; thus only rarely will a conflict arise." Another observer described the attitude of most expectant mothers more graphically: "The vast majority of women will accept significant risk, pain, and inconvenience to give their babies the best chance possible. One obstetrician who performs innovative fetal surgery stated that most of the women he sees 'would cut off their heads to save their babies.' " Rhoden, *The Judge in the Delivery Room: The Emergence of Court–Ordered Cesareans,* 74 CALIF.L.REV. 1951, 1959 (1986).

8 To the contrary, it appears that a majority of courts faced with this issue have found that the state's compelling interest in protection of the unborn child should prevail. *See* Noble–Allgire, *Court–Ordered Cesarean Sections,* 10 J. LEGAL MED. 211, 236 (1989). I add that in mapping this uncharted area of the law, we can draw lines, and a line I would draw would be to preclude the use of physical force to perform an operation. The force of the court order itself as well as the use of the contempt power would, I think, be adequate in most cases. *See id.* at 243.

9 The opinion of Superior Court Judge Richard A. Levie in *Madyun* is attached as an appendix to this opinion.

10 The Washington Post, Dec. 13, 1988, at D1.

11 For a thoughtful proposal for judicial standards in this area, *see* Noble–Allgire, *supra,* 10 J. LEGAL MED. at 244–48. And for a considered proposal for the standards to be used where the wishes of the mother conflict with the interests of her unborn child in the related area of medical treatment of the fetus, *see* Comment, *The Fetal Patient and the Unwilling Mother: A Standard for Judicial Intervention,* 14 PAC.L.J. 1065, 1093 (1983).

12 In *Thornburgh v. American College of Obstetricians & Gynecologists,* 476 U.S. 747, 106 S.Ct. 2169, 90 L.Ed.2d 779 (1986), a case involving abortion, the Supreme Court repeated its view that any trade-off between the woman's health and additional chances of fetal survival was undesirable. *Id.* at 769, 106 S.Ct. at 2183. Whether this applies to caesarean cases is unclear. *See Noble–Allgire, supra,* 10 J.LEGAL MED. at 239.

13 Although avoiding impairment is a legitimate concern, it would be inappropriate for a court to weigh against the unborn child the possibility that it would be "handicapped" or "flawed" at birth because such persons can have lives and can enrich the lives of others.

14 An additional factor, which is difficult to assess but probably deserves some consideration, is that caesarean deliveries are quite common. According to the Bureau of the Census, the Department of Commerce, 24.1 per cent of all births were by caesarean section in the year 1986, the latest year for which it furnished statistics. STATISTICAL ABSTRACT OF THE UNITED STATES 65 (109th ed. 1989). Without detracting from the seriousness of the caesarean procedure, its invasiveness, and the somewhat greater risk it entails, it seems reasonable to consider the fact that nearly a quarter of all births are caesarean not only in the substituted judgment analysis but also in the balancing analysis that should resolve a conflict between mother and unborn child.

15 I note that there was no evidence in this case that the caesarean procedure was likely to shorten A.C.'s life. Although the trial judge alluded in his findings to testimony to that effect, he was apparently referring to argument of counsel rather than testimony. After the judge's findings were made, the record was reopened to receive information from Dr. Hamner who had just spoken to A.C. In reporting that she seemed more lucid and had three times answered that she assented to a caesarean delivery, he said he had asked her if she realized that she "may not survive the surgical procedure." Because Dr. Hamner had already testified that in his opinion A.C. had less than twenty-four hours to live, and because he presumably was concerned with obtaining the consent of a patient informed of even those risks that were less than probable, this cannot be deemed the statement of an opinion that the surgery would probably shorten A.C.'s life.

16 The majority states that "a remand for supplemental findings would be inappropriate and futile because the caesarean has been performed and cannot be undone" and remands for "such further proceedings as may be appropriate." Majority opinion at 1253. Yet one of the two grounds the majority assigns for nonmootness is that "resolution of the legal issues might affect a separate action, actual or prospective, between the parties." Majority opinion at 1241–1242. The trial judge who heard the testimony is still available, and a transcript of the testimony has been prepared. The evidence would support either a finding that A.C.'s substituted judgment would be to undergo the surgery or a finding to the contrary. Because we have held the case not moot, I would remand for findings on that issue.

1 Although the Court prepared interim findings of fact and conclusions of law on July 26, 1986, this Memorandum Opinion and Order is a more detailed explication of the basis for the Court's decision in accordance with the testimony adduced at the hearing.

2 The interim Findings and Conclusions of the Court were read to the Court of Appeals and are attached hereto.

3 Mrs. Madyun testified that her membrane had ruptured at noon on July 23, 1986.

4 While use of an internal fetal monitor was not permitted by Mr. and Mrs. Madyun, an external monitor was attached.

5 Once delivered, neither Mr. nor Mrs. Madyun seemed to object to employment of medication to treat any infection of the baby.

6 At no time did the Court or counsel question the legal competence of either parent.

7 None of counsel present at the hearing questioned the competence or expertise of Dr. Cummings. Based upon Dr. Cummings' education and experience, the Court was satisfied with respect to the doctor's expertise and competence.

8 The only symptom present here was a slightly elevated maternal temperature.

9 Excluding any examinations at Greater Southeast, Mrs. Madyun had experienced ten vaginal exams since admission to the Hospital. The number of examinations also increases the risk of introducing infection into the body.

10 Realizing that normal obstetrical criteria calls for delivery within 24 hours of rupture, and the unchanged degree of dilation for almost 12 hours, Dr. Cummings believed that protrusion (a labor inducer) was not appropriate.

11 Viability is when the fetus "is, potentially able to live outside the mother's womb, albeit with artificial aid...." (footnote omitted). *Roe v. Wade,* 410 U.S. at 160 [93 S.Ct. at 730].

12 *See also, Raleigh Fitkin–Paul Morgan Mem. Hosp. v. Anderson,* 201 A.2d 537 (blood transfusion necessary to save life of mother and unborn infant (32 wks.) ordered over religious objections); *Application of Jamaica Hosp.,* 491 N.Y.S.2d 898 (blood transfusion ordered over religious objections to stabilize condition of mother and save unborn child that was not yet viable).

13 A case such as this puts the Hospital and its staff in an awkward position.

> Hospitals exist to aid the sick and the injured. The medical and nursing professions are consecrated to preserving life. That is their professional creed. To them, a failure to use a simple, established procedure in the circumstances of this case would be malpractice, however the law may characterize that failure because of the patient's private convictions. A surgeon should not be asked to operate under the strain of knowing that a transfusion may not be administered even though medically required to save his patient. The hospital and its staff should not be required to decide whether the patient is or continues to be competent to make a judgment upon the subject, or whether the release tendered by the patient or a member of his family will protect them from civil responsibility.

John F. Kennedy Mem. Hosp. v. Heston, 279 A.2d at 673.

294 Ill.App.3d 159
Appellate Court of Illinois,
First District, Fifth Division.

In re Fetus BROWN (The People of the State of Illinois, Petitioner–Appellee, v. Darlene Brown, Respondent–Appellant, and The Public Guardian of Cook County, Respondent–Appellant/Cross–Appellee).

No. 1–96–2316.
|
Dec. 31, 1997.

Synopsis

Mother appealed from order of the Circuit Court, Cook County, William F. Ward, Jr., J., appointing guardian ad litem to represent alleged interests of her viable fetus in opposition to her express refusal to undergo blood transfusion on religious grounds. The Appellate Court, Theis, J., held that: (1) mother could not be compelled to undergo blood transfusions for the benefit of her viable fetus, and (2) trial court erred in appointing guardian ad litem to represent alleged interests of fetus.

Reversed.

Attorneys and Law Firms

****398** *****526** Patrick T. Murphy, Lee Ann Lowder, Kathleen G. Kennedy, Office of the Cook County Public Guardian, Chicago, for Fetus.

***160** Donald T. Ridley, Patterson, NY; Patricia Spaulding Moore, Chicago, for Respondent–Appellant Darlene Brown.

Richard A. Devine, State's Attorney of Cook County, Chicago (Renee Goldfarb, ***161** Kenneth T. McCurry, Nancy L. Grauer, Assistant State's Attorneys, of counsel), for Petitioner–Appellee The People.

Timothy L. Rowells, Chicago, for Amicus Curiae Watchtower Bible% Tract Society.

Opinion

Justice THEIS delivered the opinion of the court:

The issue before this court is whether a competent, pregnant woman's right to refuse medical treatment, which, in this case involves religiously offensive blood transfusions, may be overridden by the State's substantial interest in the welfare of the viable fetus.

The tensions present in this issue are palpable. Questions of morality and legality converge, requiring consideration of the obligations of a pregnant woman and of the State. As a court, we are asked to determine the proper balance of the mother's common law and constitutional interests in bodily self-determination as against the State's recognized ****399** *****527** interest in protecting the viable fetus. The facts of this difficult case are as follows.

On June 26, 1996, Darlene Brown, then 26 years old, was 34–3/7 weeks pregnant. After consulting with her treating physician, Dr. Robert Walsh, Brown was admitted into Ingalls Memorial Hospital in Harvey, Illinois, to have a cystoscopy and then to remove a urethral mass. Brown was anticipated to lose 100 cubic centimeters of blood due to the procedure. Before the surgery, Brown did not discuss with Dr. Walsh that she was a Jehovah's Witness.

During the surgery, Brown lost more blood than anticipated. After Brown lost approximately 700 cubic centimeters of blood, Dr. Walsh ordered three units of blood for transfusion. Once the blood arrived in the operating room, Brown, who was fully conscious and alert during the procedure, refused the blood, explaining that she was a Jehovah's Witness. The doctors believed Brown was competent to refuse the blood and they completed the surgery using other techniques to control her bleeding. By the end of the surgery, Brown had lost almost 1,500 cubic centimeters of blood.

After the surgery, Brown had a hemoglobin level of 4.4 grams per deciliter. A hemoglobin level of 9 to 11 or 12 grams per deciliter would be normal for a woman at this stage of pregnancy. Brown's hemoglobin level continued to drop. The morning of the court hearing, Brown's hemoglobin level was 3.4. Dr. Walsh explained that Brown's low hemoglobin level and the abrupt change in that level ***162** posed a significant, life-threatening risk both to Brown and to the fetus. After consulting with Brown and her husband, Lester Brown, as well as physicians at other hospitals, Dr. Walsh attempted to use alternative medical procedures, compatible with the beliefs of Jehovah's Witnesses, to raise Brown's hemoglobin level. Unfortunately, Brown's hemoglobin level continued to drop. Dr. Walsh spoke with numerous hematologists and

oncologists. Dr. Walsh also spoke with a renowned researcher about other possible treatments. At the time of the hearing, it was Dr. Walsh's medical opinion that if Darlene Brown did not have a blood transfusion, her chances of survival, as well as those of the fetus, were only 5%.

On June 28, 1996, the State filed a petition for adjudication of wardship and a motion for temporary custody of Baby Doe, a fetus. Both were filed pursuant to the Illinois Juvenile Court Act of 1987. 705 ILCS 405/1–1 *et seq.* (West 1996). A hearing was held the same day. Although Brown contends that she was never served, the Browns were represented by counsel at the hearing and Lester Brown was present. The court began by appointing the public guardian of Cook County, over his objection, to represent the fetus (Fetus Brown). Next, uncertain as to jurisdiction under the Juvenile Court Act, the court found it inappropriate to proceed under the State's petition for adjudication of wardship. Thus, invoking the court's equitable powers, the State filed a "Petition for Hearing on Whether a Temporary Custodian can be Appointed to Consent to a Medical Procedure: To Wit Blood Transfusion."

At the hearing, the State called Dr. Robert Walsh, Darlene's treating physician, and Kurt Johnson, the hospital administrator. Dr. Walsh testified to the facts of Darlene Brown's condition as indicated above. Dr. Walsh also stated that, from the blood transfusion, Darlene Brown had a 1 in 1,000 risk of contracting hepatitis and a 1 in 5,000 or 10,000 risk of contracting HIV. Dr. Walsh explained that the blood transfusion was necessary, not to get blood to the fetus, but rather to get oxygen to the placenta via the mother's blood. Dr. Walsh explained that, while there were other methods of oxygenation, the problem was that the maternal blood was the only medium for transporting the oxygen to the placenta.

The State then called Kurt Johnson, the senior vice-president and chief operating officer of Ingalls Memorial Hospital. Johnson testified that he was aware of the situation and of Dr. Walsh's medical opinion. Johnson also testified that he was prepared to accept temporary custody of the fetus in order to consent to the blood transfusion.

The parties stipulated that, if called to testify, Lester Brown ***163** would confirm that Darlene Brown understood the risks to herself ****400** *****528** and the fetus if she did not accept the blood transfusion. The parties further stipulated that Lester Brown supported Darlene Brown's decision not to accept the blood transfusion. At the time of the hearing, the Browns had been married for two years and both worked to take care of Darlene's eight-year-old and three-year-old daughters. The parties also stipulated that, if anything happened to Darlene Brown, Lester would continue to take care of the two surviving children and both Darlene's and Lester's parents would be available for care and support of the children. The Browns then rested.

The trial court granted the State's petition and appointed the hospital administrator as "temporary custodian of Fetus Brown, with the right to consent to one or more blood transfusions for Darlene Brown, when advised of such necessity by any attending physician." In so holding, the trial court relied on the Illinois appellate decision in *In re Baby Boy Doe,* 260 Ill.App.3d 392, 398, 198 Ill.Dec. 267, 271, 632 N.E.2d 326, 330 (1994), as well as the Illinois Supreme Court decision in *Stallman v. Youngquist,* 125 Ill.2d 267, 126 Ill.Dec. 60, 531 N.E.2d 355 (1988). The court granted the State's petition and appointed the hospital administrator as temporary custodian of Fetus Brown, with the right to consent to any and all blood transfusions for Darlene Brown when advised of such necessity by any attending physician. As alleged in the Browns' later pleadings, Darlene Brown was transfused with six units of packed red blood cells beginning on the night of June 28 and continuing to approximately noon on June 29. Further, Darlene Brown tried to resist the transfusion and the doctors "yelled at and forcibly restrained, overpowered and sedated" her.

On July 8, 1996, the court held a status hearing and found that Darlene Brown had delivered a healthy baby (Baby Doe Brown) on July 1, 1996, and that both baby and mother had been discharged from the hospital. The court then vacated the temporary custody order, dismissed the State's petition, and closed the case.

Appellant, Darlene Brown, filed a notice of appeal on July 25, 1996, pursuant to Supreme Court Rule 301 (155 Ill.2d R. 301), appealing from the circuit court's order appointing a temporary custodian for the fetus with the ability to consent, on Darlene Brown's behalf, to a blood transfusion for the viable fetus. Appellant, Patrick T. Murphy, the public guardian of Cook County, Illinois, filed a separate notice of appeal on July 8, 1996, pursuant to Supreme Court Rule 303 (155 Ill.2d R. 303), appealing from the circuit court's later order vacating temporary custody and dismissing the State's petition. The public guardian challenges the trial court's order appointing the public guardian to represent the interests of the viable fetus. ***164** As appellee, the State only challenges the

issues raised on appeal by Darlene Brown. For the following reasons, we find that the trial court erred in appointing a temporary custodian for Fetus Brown with the ability to consent on behalf of Darlene Brown to a blood transfusion for the viable fetus.

We note that the factual controversy has been resolved. Darlene Brown received the blood transfusions on June 28–29, 1996, and delivered a healthy baby on July 1, 1996. While the factual issues are moot, the remaining legal issue satisfies the public policy exception to the Illinois mootness doctrine. *People ex rel. Wallace v. Labrenz,* 411 Ill. 618, 622, 104 N.E.2d 769, 772 (1952). The issue is a public one requiring authoritative determination for the future guidance of public officials, especially given the emergency and expedited nature of such proceedings. *Labrenz,* 411 Ill. at 622, 104 N.E.2d at 772. The Illinois Supreme Court has issued opinions in three blood transfusion cases despite potential mootness considerations. *In re E.G.,* 133 Ill.2d 98, 139 Ill.Dec. 810, 549 N.E.2d 322 (1989); *In re Estate of Brooks,* 32 Ill.2d 361, 205 N.E.2d 435 (1965); *People ex rel. Wallace v. Labrenz,* 411 Ill. 618, 622, 104 N.E.2d 769, 772 (1952).

Additionally, the trial court properly invoked jurisdiction under its equitable powers as a court of general jurisdiction. The same avenue was taken by the trial court in *In re Baby Boy Doe. In re Baby Boy Doe,* 260 Ill.App.3d 392, 397, 198 Ill.Dec. 267, 270, 632 N.E.2d 326, 329 (1994), *appeal denied,* No. 76560. Pursuant to the Illinois Constitution, the circuit court has subject matter ****401 ***529** jurisdiction extending to all justiciable matters, with certain limited exceptions, as invoked by the filing of a complaint or petition. Ill. Const.1970, art. VI, § 9; *City of Chicago v. Chicago Board of Education,* 277 Ill.App.3d 250, 261, 213 Ill.Dec. 817, 824, 660 N.E.2d 74, 81 (1995). We find that the circuit court had jurisdiction to hear this cause.

Turning to the merits, on appeal, Darlene Brown challenges the propriety of the trial court's order appointing a temporary custodian to consent, on her behalf, to blood transfusions for the benefit of her viable fetus, Fetus Brown. Darlene Brown contends that, under federal and Illinois law, as a competent adult, she has an absolute right to refuse medical advice and treatment. In contrast, the State urges that its substantial interest in the viable fetus outweighs the minimal invasion presented by the blood transfusion. The public guardian also appeals, seeking guidance regarding its role as protector of fetal rights, in light of prior Illinois decisions, including *In re Baby Boy Doe,* 260 Ill.App.3d 392, 198 Ill.Dec. 267, 632 N.E.2d 326 (1994).

The springboard for this case is the appellate decision in *In re Baby Boy Doe,* 260 Ill.App.3d 392, 198 Ill.Dec. 267, 632 N.E.2d 326 (1994). In *Baby Boy Doe,* ***165** the appellate court was asked to decide whether the circuit court should balance the rights of the unborn but viable fetus against the right of the competent woman to choose the type of medical care she deemed appropriate, based in part on personal religious considerations. *Baby Boy Doe,* 260 Ill.App.3d at 398, 198 Ill.Dec. at 271, 632 N.E.2d at 330.

The *Baby Boy Doe* court first considered the opinion of the Illinois Supreme Court in *Stallman v. Youngquist,* 125 Ill.2d 267, 126 Ill.Dec. 60, 531 N.E.2d 355 (1988). In *Stallman,* the court determined that a tort cause of action may not be maintained by a fetus against its mother for the unintentional infliction of prenatal injuries. *Stallman,* 125 Ill.2d at 271, 126 Ill.Dec. at 61–61, 531 N.E.2d at 356–57. In so deciding, the *Stallman* court reasoned that "the law will not treat a fetus as an entity which is entirely separate from its mother." *Stallman,* 125 Ill.2d at 277, 126 Ill.Dec. at 63, 531 N.E.2d at 359. Moreover, the court stated that, in Illinois, a fetus cannot have rights superior to those of its mother. *Stallman,* 125 Ill.2d at 276, 126 Ill.Dec. at 63, 531 N.E.2d at 359. The court thus held that a pregnant woman owes no legally cognizable duty to her developing fetus. *Stallman,* 125 Ill.2d at 280, 126 Ill.Dec. at 65, 531 N.E.2d at 361.

Following the reasoning of *Stallman,* the *Baby Boy Doe* court held that Illinois courts should not engage in a balancing of the maternal and fetal rights such that "a woman's competent choice in refusing medical treatment as invasive as a cesarean section during her pregnancy must be honored, even in circumstances where the choice may be harmful to her fetus." *Baby Boy Doe,* 260 Ill.App.3d at 398, 198 Ill.Dec. at 271, 632 N.E.2d at 330. In reaching this decision, the *Baby Boy Doe* court applied the rationale of *Stallman* to determine:

> "[A] woman's right to refuse invasive medical treatment, derived from her rights to privacy, bodily integrity, and religious liberty, is not diminished during pregnancy. The woman retains the same right to refuse invasive treatment, even of lifesaving or other beneficial nature, that she can exercise when she is not pregnant. The potential impact upon the fetus is not legally relevant; to the contrary, the *Stallman* court explicitly rejected the view that the woman's rights can be subordinated to fetal rights." *Baby Boy Doe,*

260 Ill.App.3d at 401, 198 Ill.Dec. at 273, 632 N.E.2d at 332.

In *dicta,* however, the *Baby Boy Doe* court left open the question of whether blood transfusions, involving "relatively noninvasive and risk-free" procedures, could permissibly be ordered in such a circumstance. *Baby Boy Doe,* 260 Ill.App.3d at 402, 198 Ill.Dec. at 274, 632 N.E.2d at 333.

The stage being set, the issue presented in this case is somewhat different from that presented in *Baby Boy Doe.* In *Baby Boy Doe,* both ***166** the State and the public guardian urged a balancing of the mother's rights against the putative rights of the viable fetus. Based on *Stallman,* the court in *Baby Boy Doe* refused to engage in such a balancing. ****402** *****530** *Baby Boy Doe,* 260 Ill.App.3d at 393, 198 Ill.Dec. at 267, 632 N.E.2d at 326. In this case, the State urges, not that we balance the mother's interests against those of the fetus, but rather the State's interests in the viable fetus as against the mother's expressed desire to forego a blood transfusion.

In contrast, Darlene Brown urges that she holds an absolute right to refuse medical treatment grounded in Illinois common and statutory law, and based on the Illinois and United States Constitutions. Brown also argues that the *Baby Boy Doe* court's determination that blood transfusions are "minimally invasive" is not a valid legal basis for divining when a patient's right to refuse treatment will be followed. Specifically, Brown argues that to qualify the patient's choice in refusing treatment undermines the patient's authority to make a competent treatment decision.

Illinois recognizes a common law right of competent adults to refuse medical treatment. *In re E.G.,* 133 Ill.2d 98, 106, 139 Ill.Dec. 810, 813, 549 N.E.2d 322, 325 (1989). The right to refuse such treatment is based on the doctrine of informed consent, which requires physicians to obtain consent before performing any medical surgery or procedure upon a patient. *In re Estate of Longeway,* 133 Ill.2d 33, 45, 139 Ill.Dec. 780, 785, 549 N.E.2d 292, 297 (1989). The right to refuse treatment anticipates all forms of medical treatment, including life-saving and life-sustaining procedures (*Longeway,* 133 Ill.2d at 45, 139 Ill.Dec. at 785, 549 N.E.2d at 297), and includes the refusal of blood transfusions. *In re E.G.,* 133 Ill.2d at 106, 139 Ill.Dec. at 813, 549 N.E.2d at 325; *In re Estate of Brooks,* 32 Ill.2d 361, 365, 205 N.E.2d 435, 438 (1965). But see *People ex rel. Wallace v. Labrenz,* 411 Ill. 618, 620, 104 N.E.2d 769, 771 (1952) (State can require blood transfusion for eight-day-old infant over the religious objections of the infant's parents).

The United States Supreme Court has stated that a person's interest in refusing medical treatment has constitutional underpinnings in the due process clause of the fourteenth amendment to the United States Constitution. In *Cruzan v. Director, Missouri Department of Health,* 497 U.S. 261, 279, 110 S.Ct. 2841, 2851–52, 111 L.Ed.2d 224, 242 (1990), the United States Supreme Court explained that a patient has a liberty interest in refusing medical treatment which must be balanced in a given case against the relevant State interests.

The Illinois Supreme Court has declined to construe the right of privacy under the Illinois Constitution to include a right to refuse ***167** medical treatment. *In re C.E.,* 161 Ill.2d 200, 212–13, 204 Ill.Dec. 121, 127, 641 N.E.2d 345, 351 (1994). The supreme court, however, has indicated that religious-based objections to medical treatment find constitutional protection under the first amendment to the United States Constitution. *In re E.G.,* 133 Ill.2d at 106, 139 Ill.Dec. at 813, 549 N.E.2d at 325; *Estate of Brooks,* 32 Ill.2d at 372, 205 N.E.2d at 441–42.

The right to refuse medical treatment, however, is not absolute. *In re E.G.,* 133 Ill.2d at 111, 139 Ill.Dec. at 816, 549 N.E.2d at 328. The State may intervene in a given case if the State's interests outweigh the interests of the patient in refusing medical treatment. This is true whether the refusal is based on common law or constitutional principles. *Cruzan,* 497 U.S. at 279, 110 S.Ct. at 2852, 111 L.Ed.2d at 242; *In re Estate of Longeway,* 133 Ill.2d at 48, 139 Ill.Dec. at 787, 549 N.E.2d at 299. Generally, courts consider four State interests—the preservation of life, the prevention of suicide, the protection of third parties, and the ethical integrity of the medical profession—when deciding whether to override competent treatment decisions. *Application of the President & Directors of Georgetown College, Inc.,* 331 F.2d 1000, 1006–07 (D.C.Cir.1964); *Baby Boy Doe,* 260 Ill.App.3d at 404, 198 Ill.Dec. at 275, 632 N.E.2d at 334; *Superintendent of Belchertown State School v. Saikewicz,* 373 Mass. 728, 741, 370 N.E.2d 417, 425 (1977). See also *Compassion in Dying v. State of Washington,* 79 F.3d 790, 816 (9th Cir.1996) (finding six state interests, cited with approval on writ of *certiorari, Washington v. Glucksberg,* 521 U.S. 702, ——– – ——– n. 21, 117 S.Ct. 2258, 2271–72 n. 21, 138 L.Ed.2d 772, 792–93 n. 21 (1997)).

In this case, the circuit court considered the four state interests set forth above and ****403** *****531** determined: (1) the transfusion was necessary to preserve the life of Darlene

and the fetus; (2) the prevention of suicide was not at issue because Darlene had clearly stated her desire to accept medical treatment, other than a blood transfusion; (3) the State's interest in protecting third parties was strong because Darlene has two minor children, ages three and eight, who would be orphaned if she did not receive the transfusion; and (4) the transfusion procedure would be minimally invasive and could "be administered without additional pain or intrusion because Darlene already [had] two intravenous sites."

We agree with the circuit court that prevention of suicide is not at issue. Darlene Brown consented to and sought all possible medical treatment except blood transfusions. Likewise, the State's interest in maintaining the ethical integrity of the medical profession is not dispositive. This interest seeks to protect the role of hospitals in fully caring for their patients as well as to promote the prevailing medical ethical standards. *Superintendent of Belchertown,* 373 Mass. at 743–44, 370 N.E.2d at 426. ***168** Although some hospitals have sought judicial determination of their role in these matters (see *In re Dubreuil,* 629 So.2d 819 (Fla.1994)), the American Medical Association Board of Trustees generally recommends that "[j]udicial intervention is inappropriate when a woman has made an informed refusal of a medical treatment designed to benefit her fetus." H. Cole, *Legal Interventions During Pregnancy,* 264 JAMA 2603, 2670 (1990). Accordingly, this interest does not provide a definitive solution.

The next factor is the State's interest in preservation of life. The circuit court found that the State had an interest in preserving both the life of the mother and the fetus. Typically, however, this factor concerns only preservation of the life of the decision maker. *Baby Boy Doe,* 260 Ill.App.3d at 404, 198 Ill.Dec. at 275, 632 N.E.2d at 334. As one court noted:

> "[T]he State's concern is weakened when the decision maker (the individual who refuses to consent to the treatment) is also the patient 'because the life that the state is seeking to protect in such a situation is the life of the same person who has competently decided to forgo the medical intervention; it is not some other actual or potential life that cannot adequately protect itself.' " *Norwood Hospital v. Munoz,* 409 Mass. 116, 125–26, 564 N.E.2d 1017, 1023 (1991), citing *Matter of Conroy,* 98 N.J. 321, 349, 486 A.2d 1209, 1223 (1985).

Most cases concern competent adults who are not pregnant. Of the cases concerning a pregnant woman, most concern the woman's refusal of medical treatment *after* the birth of the child, and, thus, the woman's wishes are respected. *Stamford Hospital v. Vega,* 236 Conn. 646, 674 A.2d 821 (1996); *Fosmire v. Nicoleau,* 75 N.Y.2d 218, 225, 551 N.E.2d 77, 80, 551 N.Y.S.2d 876, 879 (1990). Although *Baby Boy Doe* was a pregnancy case, the court found the preservation-of-life factor irrelevant as the cesarean section procedure, although necessary for the health of the fetus, was not necessary to preserve the mother's life or health. In fact, the court found that the procedure posed a greater risk to the mother's health. *Baby Boy Doe,* 260 Ill.App.3d at 404, 198 Ill.Dec. at 275, 632 N.E.2d at 334. Only in the instant case are we confronted with a situation in which both the pregnant mother and the viable fetus were to benefit from the proposed blood transfusions. We determine that the State's interest in preservation of life continues to concern the life of the decision maker.

Illinois public policy values the sanctity of life. *In re E.G.,* 133 Ill.2d at 110, 139 Ill.Dec. at 815, 549 N.E.2d at 327. Along with the State's interest in preservation of life, however, must be considered the State's interest in protecting the autonomy of the individual. "[T]he State rarely acts to ***169** protect individuals from themselves * * *. This is consistent with the primary function of the State to preserve and promote liberty and the personal autonomy of the individual." *Fosmire v. Nicoleau,* 75 N.Y.2d 218, 227, 551 N.E.2d 77, 81–82, 551 N.Y.S.2d 876, 880–81 (1990).

Illinois statutorily recognizes a competent adult's decision to refuse medical treatment. The Health Care Surrogate Act provides that the "legislature recognizes that all persons ****404** *****532** have a fundamental right to make decisions relating to their own medical treatment, including the right to forgo life-sustaining treatment." 755 ILCS 40/5 (West 1996). The intent of the Act is:

> "[T]o define the circumstances under which private decisions by patients with decisional capacity and by surrogate decision makers on behalf of patients lacking decisional capacity *to make medical treatment decisions or* to terminate life-sustaining treatment may be made without judicial involvement of any kind." (Emphasis indicates change in statute.) 755 ILCS 40/5 (West 1996) (as amended by Pub. Act 90–246, § 5, eff. January 1, 1998).

Section 20 of the Act provides that "[d]ecisions whether to forgo life-sustaining or any other form of medical treatment involving an adult patient with decisional capacity may be made by that adult patient." 755 ILCS 40/20(a) (West 1996). Construing the State's interest in preserving life in

conjunction with its interest in protecting the autonomy of the individual, we find that the State's interest in preserving Darlene Brown's life is not determinative in this case.

Thus, the final State interest is the impact upon third parties. Most cases have considered this interest in the context of the impact upon the minor children of a woman refusing medical treatment. *Application of the President & Directors of Georgetown College, Inc.,* 331 F.2d 1000, 1006–07 (D.C.Cir.1964). But see *In re E.G.,* 133 Ill. 2d at 111–12, 139 Ill.Dec. at 816, 549 N.E.2d at 328 (noting the impact of a mature minor's decision to refuse a blood transfusion upon parents, guardians, adult siblings, and other relatives).

Some courts have found that the state's interest in the welfare of third parties cannot be determinative of the patient's right to refuse medical treatment. *Fosmire v. Nicoleau,* 75 N.Y.2d 218, 230, 551 N.E.2d 77, 83–84, 551 N.Y.S.2d 876, 882–83 (1990). Other courts have declined to go so far, instead holding that where there is no evidence of the minor children's abandonment, such an interest will not override the patient's competent refusal. *Norwood Hospital,* 409 Mass. at 129, 564 N.E.2d at 1024.

Here, the record does not indicate evidence of abandonment of the minor children. Lester Brown, the natural father of the three-year-old, supported Darlene's decision to refuse consent. While there ***170** is no evidence in the record regarding the eight-year-old's natural father, Lester Brown as well as his and Darlene's parents all were willing to help support both minor children. Thus, the State's interest in protecting the living minor children is not determinative.

We therefore encounter the ultimate issue, the State's interest in protecting the viable fetus. In *Roe v. Wade,* the United States Supreme Court explained that the state maintains an "important and legitimate interest in preserving and protecting the health of the pregnant woman * * * [and] the potentiality of human life." *Roe v. Wade,* 410 U.S. 113, 162, 93 S.Ct. 705, 731, 35 L.Ed.2d 147, 182 (1973). In fact, the State maintains "a substantial interest in potential life throughout pregnancy." *Planned Parenthood of Southeastern Pa. v. Casey,* 505 U.S. 833, 876, 112 S.Ct. 2791, 2820, 120 L.Ed.2d 674, 714 (1992). In the abortion context, the state's important and legitimate interest becomes compelling at viability. At that point, the state may restrict abortion, except when necessary to preserve the life or health of the mother. *Roe,* 410 U.S. at 163–64, 93 S.Ct. at 732, 35 L.Ed.2d at 182–83.

In Illinois, the Illinois Constitution and Illinois Supreme Court have both been silent regarding the State's interest in a viable fetus. Under the Illinois Abortion Law of 1975:

> "Without in any way restricting the right of privacy of a woman or the right of a woman to an abortion under [the decisions of the United States Supreme Court of January 22, 1973], * * * [an] unborn child is a human being from the time of conception and is, therefore, a legal person for purposes of the unborn child's right to life and is entitled to the right to life from conception under the laws and Constitution of this State." 720 ILCS 510/1 (West 1996).

The Act defines viability as "that stage of fetal development when, in the medical judgment of the attending physician based on the ****405** *****533** particular facts of the case before him, there is a reasonable likelihood of sustained survival of the fetus outside the womb, with or without artificial support." 720 ILCS 510/2(1) (West 1996).

To date, a fetus is not considered a minor for purposes of the Illinois Juvenile Court Act. See *Baby Boy Doe,* 260 Ill.App.3d at 398, 198 Ill.Dec. at 271, 632 N.E.2d at 330. Illinois courts have, however, found viable fetuses to be persons with regard to wrongs caused by third parties, but they have distinguished such injuries from those caused by the mother. See *Cullotta v. Cullotta,* 287 Ill.App.3d 967, 969–70, 222 Ill.Dec. 845, 846, 678 N.E.2d 717, 718 (1997).

In examining the State's interest in the viable fetus, we note the distinct circumstances of this case. This is not an abortion case in ***171** which a pregnant woman seeks to terminate an unwanted pregnancy. Likewise, this case does not involve substance abuse or other abuse by a pregnant woman. And while refusal to consent to a blood transfusion for an infant would constitute neglect (see *Labrenz,* 411 Ill. at 624, 104 N.E.2d at 773), without a determination by the Illinois legislature that a fetus is a minor for purposes of the Juvenile Court Act, we cannot separate the mother's valid treatment refusal from the potential adverse consequences to the viable fetus.

Consequently, following the lead of *Baby Boy Doe* and *Stallman,* and in this case balancing the mother's right to refuse medical treatment against the State's substantial interest in the viable fetus, we hold that the State may not override a pregnant woman's competent treatment decision, including refusal of recommended invasive medical procedures, to potentially save the life of the viable fetus.

We disagree with the *Baby Boy Doe* court's suggestion that a blood transfusion constitutes a "relatively noninvasive and risk-free procedure" (*Baby Boy Doe,* 260 Ill.App.3d at 402, 198 Ill.Dec. at 274, 632 N.E.2d at 333), and find that a blood transfusion is an invasive medical procedure that interrupts a competent adult's bodily integrity. We thus determine that the circuit court erred in ordering Brown to undergo the transfusion on behalf of the viable fetus.

In reaching this difficult conclusion, we note the mother's apparent disparate ethical and legal obligations. Under the law of this State, however, we cannot impose a legal obligation upon a pregnant woman to consent to an invasive medical procedure for the benefit of her viable fetus. As noted by the United States Supreme Court in *Planned Parenthood v. Casey:*

> "[T]he liberty of the woman is at stake in a sense unique to the human condition and so unique to the law. The mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear. That these sacrifices have from the beginning of the human race been endured by woman with a pride that ennobles her in the eyes of others and gives to the infant a bond of love cannot alone be grounds for the State to insist she make the sacrifice. Her suffering is too intimate and personal for the State to insist, without more, upon its own vision of the woman's role, however dominant that vision has been in the course of our history and our culture. The destiny of the woman must be shaped to a large extent on her own conception of her spiritual imperatives and her place in society." *Casey,* 505 U.S. at 852, 112 S.Ct. at 2807, 120 L.Ed.2d at 698–99.

From a practical standpoint, this court questions the enforcement of such court orders, even assuming their validity. The court in *Baby Boy Doe* noted the practical difficulties of enforcing such orders. ***172** *Baby Boy Doe,* 260 Ill.App.3d at 405–06, 198 Ill.Dec. at 276, 632 N.E.2d at 335. Such an order would be in the nature of an injunction, issued by the court and requiring the mother to consent. *In re A. Minor,* 127 Ill.2d 247, 261, 130 Ill.Dec. 225, 231, 537 N.E.2d 292, 298 (1989). The only enforcement of such injunctive orders is a contempt citation issued against the mother for willfully violating an order of the court. *Fidelity Financial Services, Inc. v. Hicks,* 267 Ill.App.3d 887, 890, 204 Ill.Dec. 858, 860, 642 N.E.2d 759, 761 (1994). "Contempt is punishable by the imposition of a fine, imprisonment, or other ****406** *****534** sanction." *Fidelity Financial,* 267 Ill.App.3d at 890, 204 Ill.Dec. at 860, 642 N.E.2d at 761. We question the efficacy of a court order requiring a blood transfusion for someone who is facing death.

As a final matter, the public guardian's appeal argues that, in light of *In re Baby Boy Doe,* the circuit court erred in appointing a guardian *ad litem* to represent the alleged interests of the viable fetus in opposition to the express wishes of its mother. Invoking the provision in the Illinois Abortion Law of 1975 stating that an unborn child is a human being from the time of conception and a legal person, the circuit court determined that it had authority to appoint a guardian *ad litem* for Fetus Brown. 720 ILCS 510/1 (West 1996).

Although the public guardian is correct that *Baby Boy Doe* held that the mother's rights and the fetus' rights may not be balanced, this case did not involve such a balancing. Instead, the issue as framed in this case involved the mother's right to refuse medical treatment as considered against the State's interest in the viable fetus. The asserted legal interests did not require the public guardian's representation of the separate, putative interests of the viable fetus. Thus, the circuit court erred in appointing the public guardian to represent the interests of the viable fetus in this case.

In conclusion, the circuit court erred in appointing a temporary custodian for Fetus Brown with the authority to consent to blood transfusions for Darlene Brown and erred in appointing the public guardian as guardian *ad litem* for Fetus Brown.

Reversed.

GREIMAN and ZWICK, JJ., concur.

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WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

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Committee on Ethics

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While this document reflects the current viewpoint of the College, it is not intended to dictate an exclusive course of action in all cases. This Committee Opinion was approved by the Committee on Ethics and the Executive Board of the American College of Obstetricians and Gynecologists.

Refusal of Medically Recommended Treatment During Pregnancy

ABSTRACT: One of the most challenging scenarios in obstetric care occurs when a pregnant patient refuses recommended medical treatment that aims to support her well-being, her fetus's well-being, or both. In such circumstances, the obstetrician–gynecologist's ethical obligation to safeguard the pregnant woman's autonomy may conflict with the ethical desire to optimize the health of the fetus. Forced compliance—the alternative to respecting a patient's refusal of treatment—raises profoundly important issues about patient rights, respect for autonomy, violations of bodily integrity, power differentials, and gender equality. The purpose of this document is to provide obstetrician–gynecologists with an ethical approach to addressing a pregnant woman's decision to refuse recommended medical treatment that recognizes the centrality of the pregnant woman's decisional authority and the interconnection between the pregnant woman and the fetus.

When a pregnant woman refuses medically recommended treatment, her decision may not result in optimal fetal well-being, which creates an ethical dilemma for her obstetrician–gynecologist. In such circumstances, the obstetrician–gynecologist's ethical obligation to safeguard the pregnant woman's autonomy may conflict with the ethical desire to optimize the health of the fetus. The obstetrician–gynecologist's professional obligation to respect a pregnant patient's refusal of treatment may conflict with his or her personal values. Forced compliance—the alternative to respecting a patient's refusal of treatment—raises profoundly important issues about patient rights, respect for autonomy, violations of bodily integrity, power differentials, and gender equality. Coercive interventions often are discriminatory and act as barriers to needed care.

The purpose of this document is to provide obstetrician–gynecologists with an ethical approach to addressing a pregnant woman's decision to refuse recommended medical treatment that recognizes the centrality of the pregnant woman's decisional authority and the interconnection between the pregnant woman and the fetus. This document is not intended to address professional liability or legal issues that may arise in association with decision making when a pregnant woman refuses medically recommended treatment. Information regarding professional and legal issues is available elsewhere (see www.acog.org/About-ACOG/ACOG-Departments/Professional-Liability and the American Congress of Obstetricians and Gynecologists' *Professional Liability and Risk Management: An Essential Guide for Obstetrician–Gynecologists*, 3rd edition). Fellows are encouraged to seek legal advice when concerns arise regarding professional liability or the legal implications of their actions.

Recommendations

On the basis of the principles outlined in this Committee Opinion, the American College of Obstetricians and Gynecologists (the College) makes the following recommendations:

- Pregnancy is not an exception to the principle that a decisionally capable patient has the right to refuse

treatment, even treatment needed to maintain life. Therefore, a decisionally capable pregnant woman's decision to refuse recommended medical or surgical interventions should be respected.

- The use of coercion is not only ethically impermissible but also medically inadvisable because of the realities of prognostic uncertainty and the limitations of medical knowledge. As such, it is never acceptable for obstetrician–gynecologists to attempt to influence patients toward a clinical decision using coercion. Obstetrician–gynecologists are discouraged in the strongest possible terms from the use of duress, manipulation, coercion, physical force, or threats, including threats to involve the courts or child protective services, to motivate women toward a specific clinical decision.
- Eliciting the patient's reasoning, lived experience, and values is critically important when engaging with a pregnant woman who refuses an intervention that the obstetrician–gynecologist judges to be medically indicated for her well-being, her fetus's well-being, or both. Medical expertise is best applied when the physician strives to understand the context within which the patient is making her decision.
- When working to reach a resolution with a patient who has refused medically recommended treatment, consideration should be given to the following factors: the reliability and validity of the evidence base, the severity of the prospective outcome, the degree of burden or risk placed on the patient, the extent to which the pregnant woman understands the potential gravity of the situation or the risk involved, and the degree of urgency that the case presents. Ultimately, however, the patient should be reassured that her wishes will be respected when treatment recommendations are refused.
- Obstetrician–gynecologists are encouraged to resolve differences by using a team approach that recognizes the patient in the context of her life and beliefs and to consider seeking advice from ethics consultants when the clinician or the patient feels that this would help in conflict resolution.
- The College opposes the use of coerced medical interventions for pregnant women, including the use of the courts to mandate medical interventions for unwilling patients. Principles of medical ethics support obstetrician–gynecologists' refusal to participate in court-ordered interventions that violate their professional norms or their consciences. However, obstetrician–gynecologists should consider the potential legal or employment-related consequences of their refusal. Although in most cases such court orders give legal permission for but do not require obstetrician–gynecologists' participation in forced medical interventions, obstetrician–gynecologists who find themselves in this situation should familiarize themselves with the specific circumstances of the case.
- It is not ethically defensible to evoke conscience as a justification to attempt to coerce a patient into accepting care that she does not desire.
- The College strongly discourages medical institutions from pursuing court-ordered interventions or taking action against obstetrician–gynecologists who refuse to perform them.
- Resources and counseling should be made available to patients who experience an adverse outcome after refusing recommended treatment. Resources also should be established to support debriefing and counseling for health care professionals when adverse outcomes occur after a pregnant patient's refusal of treatment.

Refusal of Treatment

When a pregnant woman refuses recommended medical treatments or chooses not to follow medical recommendations, there can be a range of minor to major risks to the patient or the fetus. In certain situations, a pregnant woman might refuse therapies that the medical professional believes are necessary for her health or survival, that of her fetus, or both. Examples of these situations include a pregnant woman refusing to treat a fetal condition or infection in utero or to undergo cesarean delivery when it is thought to be medically necessary to avoid an adverse fetal or maternal outcome.

Such cases can be distressing for the health care team. Obstetrician–gynecologists may feel deep concern for the pregnant woman and fetus entrusted to their care, worry about the pregnant woman's reaction if a potentially avoidable adverse outcome occurs, or be apprehensive regarding liability issues resulting from an adverse outcome. Members of the health care team may disagree about case management and feel uneasy about their roles or even experience moral distress (1).

In these circumstances, as in all clinical encounters, the obstetrician–gynecologist's actions should be guided by the ethical principle that adult patients who are capable decision makers have the right to refuse recommended medical treatment. This doctrine has evolved through legal cases, regulations, and statutes that have established the requirement of informed consent to medical treatment in order to effect patient self-determination and preclude violations of bodily integrity. Informed refusal is the corollary of the doctrine of informed consent; it is an ongoing process of mutual communication between the patient and the physician and enables a patient to make an informed and voluntary decision about accepting or declining medical care. The informed consent process ideally begins before decision making so that the patient is able to make an informed choice (ie, informed consent or informed refusal) based on clinical information, the

patient's values, and other considerations of importance to her.

Voluntariness is a background condition of informed consent. As noted in Committee Opinion No. 439, *Informed Consent*, "Consenting freely is incompatible with being coerced or unwillingly pressured by forces beyond oneself. It involves the ability to choose among options and select a course other than what may be recommended" (2). Pregnancy is not an exception to the principle that a decisionally capable patient has the right to refuse treatment, even treatment needed to maintain life. Therefore, a decisionally capable pregnant woman's decision to refuse recommended medical or surgical interventions should be respected.

Complexities of Refusal of Medically Recommended Treatment During Pregnancy

In obstetrics, pregnant women typically make clinical decisions that are in the best interest of their fetuses. In most desired pregnancies, the interests of the pregnant woman and the fetus converge. However, a pregnant woman and her obstetrician–gynecologist may disagree about which clinical decisions and treatments are in her best interest and that of her fetus. As with a nonpregnant patient, a pregnant woman may evaluate the risks and benefits of recommended medical treatment differently than her obstetrician–gynecologist and, therefore, may refuse recommended therapies or treatments. Such refusals are based not only on clinical considerations but also on the patient's roles and relationships; they reflect her assessment of multiple converging interests: her own, those of her developing fetus, and those of her family or community.

Special complexities are inherent in a woman's decision to refuse recommended medical treatment during pregnancy because of the presence of the fetus. The maternal–fetal relationship is unique in medicine because of the physiologic dependence of the fetus on the pregnant woman. Moreover, therapeutic access to the fetus occurs through the body of the pregnant woman. A joint guidance document from the College and the American Academy of Pediatrics states that "any fetal intervention has implications for the pregnant woman's health and necessarily her bodily integrity, and therefore cannot be performed without her explicit informed consent" (2, 3).

The emergence over the past four decades of enhanced techniques for imaging, testing, and treating fetuses has led some to endorse the notion that fetuses are independent patients with treatment options and decisions separate from those of pregnant women (4–6). Although the care model that fetuses are independent patients was meant to clarify complex issues that arise in obstetrics, many writers have noted that it instead distorts ethical and policy debates (7–11). When the pregnant woman and fetus are conceptualized as separate patients, the pregnant woman and her medical interests, health needs, and rights can become secondary to those of the fetus. At the extreme, construing the fetus as a patient sometimes can lead to the pregnant woman being seen as a "fetal container" rather than as an autonomous agent (12). In one example, researchers performing fetal surgery (interventions to correct anatomic abnormalities in utero) have been criticized for their failure to assess the effect of surgery on the pregnant women, who also undertake the risks of the surgical procedures (13).

The most suitable ethical approach for medical decision making in obstetrics is one that recognizes the pregnant woman's freedom to make decisions within caring relationships, incorporates a commitment to informed consent and refusal within a commitment to provide medical benefit to patients, and respects patients as whole and embodied individuals (14). This ethical approach recognizes that the obstetrician–gynecologist's primary duty is to the pregnant woman. This duty most often also benefits the fetus. However, circumstances may arise during pregnancy in which the interests of the pregnant woman and those of the fetus diverge. These circumstances demonstrate the primacy of the obstetrician–gynecologist's duties to the pregnant woman. For example, if a woman with severe cardiopulmonary disease becomes pregnant, and her condition becomes life threatening as a result, her obstetrician–gynecologist may recommend terminating the pregnancy. This medical recommendation would not make sense if the obstetrician–gynecologist was primarily obligated to care for the fetus (10).

Instead, it is more helpful to speak of the obstetrician–gynecologist as having beneficence-based *motivations* toward the fetus of a woman who presents for obstetric care and a beneficence-based *obligation* to the pregnant woman who is the patient. Intervention on behalf of the fetus must be undertaken through the pregnant woman's body. Thus, questions of how to care for the fetus cannot be viewed as a simple ratio of maternal and fetal risks but should account for the need to respect fundamental values, such as the pregnant woman's autonomy and control over her body (15).

Directive Counseling Versus Coercion

When a physician is faced with a situation in which a patient refuses a medical recommendation, it is useful to distinguish the use of directive counseling from efforts aimed at coercion. *Directive counseling* is defined as patient counseling in which the obstetrician–gynecologist plays an active role in the patient's decision making by offering advice, guidance, recommendations, or some combination thereof. *Coercion* is defined as the practice of compelling someone to do something by using force or threats. Directive counseling often is appropriate and typically is welcomed in the medical encounter because medical recommendations—when they are not coercive—do not violate but rather enhance the requirements of informed consent (2). However, if a patient refuses the recommended course of care, it is vitally

important that physicians recognize when they cross the line that separates directive counseling from coercion. Good intentions can lead to inappropriate behavior. The use of coercion is not only ethically impermissible but also medically inadvisable because of the realities of prognostic uncertainty and the limitations of medical knowledge. As such, it is never acceptable for obstetrician–gynecologists to attempt to influence patients toward a clinical decision using coercion. Obstetrician–gynecologists are discouraged in the strongest possible terms from the use of duress, manipulation, coercion, physical force, or threats, including threats to involve the courts or child protective services, to motivate women toward a specific clinical decision.

Although the physician aims to provide recommendations that are based on the best available medical evidence (16), data and technology are imperfect, and responses to treatment are not always predictable for a given patient. As such, it is difficult to determine the outcome of treatment––or lack of treatment––with absolute certainty. It requires a measure of humility for the obstetrician–gynecologist to acknowledge this to the patient and to herself or himself.

Because of the potential inability to determine with certainty when a situation will cause harm to the fetus, as well as the potential inability to guarantee that the pregnant woman will not be harmed by the medical intervention itself, a balance of potential outcomes that addresses the pregnant woman and her fetus should be presented. The obstetrician–gynecologist should affirm the importance of the pregnant woman's assessment of her relational interests (personal, familial, social, or community) and acknowledge prognostic uncertainty. In addition, the following should be acknowledged: the limitations of the patient's understanding of her clinical situation; cultural, social, and value differences; power differentials; and language barriers. When working to reach a resolution with a patient who has refused medically recommended treatment, consideration should be given to the following factors: the reliability and validity of the evidence base, the severity of the prospective outcome, the degree of burden or risk placed on the patient, the extent to which the pregnant woman understands the potential gravity of the situation or the risk involved, and the degree of urgency that the case presents. Ultimately, however, the patient should be reassured that her wishes will be respected when treatment recommendations are refused. When a pregnant patient refuses a recommended medical treatment, the physician should carefully document the refusal in the medical record. Examples of important information to document are as follows (17):

- The need for the treatment has been explained to the patient—including discussion of the risks and benefits of treatment, alternatives to treatment, and the risks and possible consequences of refusing the recommended treatment (including the possible risk to her health or life, the fetus's health or life, or both)
- The patient's refusal to consent to a medical treatment
- The reasons (if any) stated by the patient for such refusal

Arguments Against Court-Ordered Interventions

When the obstetrician–gynecologist and the patient are unable to agree on a plan of care and a pregnant woman continues to refuse recommended treatment, some obstetrician–gynecologists, hospital staff, or legal teams have attempted to force compliance through the courts, most notably for cesarean delivery or blood transfusion (18–20). Court-ordered interventions against decisionally capable pregnant women are extremely controversial. They exploit power differentials; involve incursions against individual rights and autonomy; and manifest as violations of bodily integrity and, often, gender and socioeconomic equality (14).

The College opposes the use of coerced medical interventions for pregnant women, including the use of the courts to mandate medical interventions for unwilling patients. Principles of medical ethics support obstetrician–gynecologists' refusal to participate in court-ordered interventions that violate their professional norms or their consciences. However, obstetrician–gynecologists should consider the potential legal or employment-related consequences of their refusal. Although in most cases such court orders give legal permission for but do not require obstetrician–gynecologists' participation in forced medical interventions, obstetrician–gynecologists who find themselves in this situation should familiarize themselves with the specific circumstances of the case. The College strongly discourages medical institutions from pursuing court-ordered interventions or taking action against obstetrician–gynecologists who refuse to perform them. It is not ethically defensible to evoke conscience as a justification to attempt to coerce a patient into accepting care that she does not desire.

Prognostic Uncertainty

Prognostic uncertainty is present to various degrees in all medical encounters across all specialties and is common enough in obstetric decision making to warrant serious concern about legal coercion and the tremendous effect on the lives and civil liberties of pregnant women that court-ordered intervention entails (15, 21). A study of court-ordered obstetric interventions suggested that in almost one third of cases in which court orders were sought, the medical judgment, in retrospect, was incorrect (22).

Barriers to Needed Care

Coercive and punitive policies are potentially counterproductive because they are likely to discourage prenatal care and successful treatment while undermining the patient–physician relationship. Attempts to criminalize

pregnant women's behavior may discourage women from seeking prenatal care (23). Likewise, court-ordered interventions and other coercive measures may result in fear on the patient's part about whether her wishes in the delivery room will be respected, which could discourage the pregnant patient from seeking care. Therefore, when obstetrician–gynecologists participate in forced treatment of their pregnant patients, outcomes for the patients and the fetuses may worsen rather than improve.

Discriminatory Effects

Coercive policies directed toward pregnant women may be disproportionately applied to disadvantaged populations. In cases of court-ordered cesarean deliveries, for instance, most court orders have been obtained against women of color or of low socioeconomic status. In a review of 21 court-ordered interventions, 81% involved women of color and 24% involved women who did not speak English as a first language (22). Likewise, a systematic review of more than 400 cases of coerced interventions found that most cases included allegations against low-income women (23). The inclusion of an ethics committee or a patient advocate could help mitigate the disproportionate application of coercive policies to certain subpopulations of women and should be made available whenever possible.

Process for Addressing Refusal of Medically Recommended Treatment During Pregnancy

Although there is no universal approach to communicating with and caring for a pregnant patient who refuses medically recommended treatment, steps can be taken to mediate conflict, diffuse intense emotions, and encourage consideration of the patient's perspective. These steps may create space, even under time constraints, to ensure that patients are fully heard and considered.

Seek to Understand the Patient's Perspective

Eliciting the patient's reasoning, lived experience, and values is critically important when engaging with a pregnant woman who refuses an intervention that the obstetrician–gynecologist judges to be medically indicated for her well-being, her fetus's well-being, or both. Medical expertise is best applied when the physician strives to understand the context within which the patient is making her decision. The obstetrician–gynecologist should acknowledge the importance of the pregnant woman's knowledge and values when making medical recommendations. A pregnant woman's decision to refuse treatment may be based on religious or cultural grounds; her assessment of the converging interests of herself, her fetus, her family, or her community; a misunderstanding of the clinical situation; or the experience of a family member or friend. Determining the basis for a pregnant woman's decision to refuse medically recommended treatment enables the physician to address her concern or understand its importance to her and then take steps toward resolution (24). To that end, effective communication skills and strategies are critically important. Use of empathic statements, listening without interrupting, and taking a short break before revisiting the case can help defuse tensions, foster a calmer atmosphere, and establish trust (25, 26). The RESPECT model (Box 1) is an example of one tool that can be used to help optimize patient-centered

Box 1. The RESPECT Communication Model

Rapport

- Connect on a social level.
- See the patient's point of view. Consciously suspend judgment. Recognize and avoid making assumptions.

Empathy

- Remember that the patient has come to you for help.
- Seek out and understand the patient's rationale for her behaviors or illness. Verbally acknowledge and legitimize the patient's feelings.

Support

- Ask about and understand the barriers to care and adherence. Help the patient overcome barriers.
- Involve family members, if appropriate.
- Reassure the patient that you are and will be able to help.

Partnership

- Be flexible with regard to control issues. Negotiate roles, when necessary.
- Stress that you are working together to address health problems.

Explanations

- Check often for understanding. Use verbal clarification techniques.

Cultural Competence

- Respect the patient's cultural beliefs.
- Understand that the patient's view of you may be defined by ethnic or cultural stereotypes.
- Be aware of your own cultural biases and preconceptions.
- Know your limitations in addressing medical issues across cultures.
- Understand your personal style and recognize when it may not be working with a given patient.

Trust

- Recognize that self-disclosure may be difficult for some patients.
- Consciously work to establish trust.

Modified with permission from Mutha S, Allen C, Welch M. Toward culturally competent care: a toolbox for teaching communication strategies. San Francisco (CA): Center for the Health Professions, University of California; 2002.

communication. Physicians also are referred to additional College resources that relate to effective communication, cultural sensitivity, empathy, and health literacy (2, 26–30).

Enhance the Patient's Understanding

Just as the patient must be free of external constraints on her freedom of choice, so must she be free of misinformation regarding the clinical factors on which the physician's medical recommendations are formulated (2, 30). Adequate disclosure of relevant information may include that which is common to the practice of the profession, the reasonable needs and expectations of an ordinary patient, and, ideally, the needs and expectations of the patient making the decision. It also is important to inform the patient that other aspects of her care are not conditioned on making a choice that her obstetrician–gynecologist might prefer. Forthright and transparent communication of clinical information should encompass the range of clinical options available to the patient, including the potential risks, benefits, and consequences of each option and the likelihood of achieving goals of care. The discussion should include the treatment option that the patient prefers, as well as the benefits, risks, and consequences of no treatment or alternative treatments. Acknowledging that the patient is free at any time to refuse or withdraw her consent is an important part of the discussion. However, the physician should attempt to give the patient as much information as possible so that she has a basic understanding of her clinical situation and the implications of not receiving the treatment. Ideally, after the patient and the physician have discussed the clinical situation and the benefits and risks of the recommended treatment or intervention, the patient should decide whether or not to proceed with the recommended treatment (informed consent) or to forgo the recommended treatment (informed refusal).

Efforts to enhance patient understanding of relevant clinical information include the use of lay language rather than technical jargon, discourse in or translation to the patient's primary language if the patient's proficiency in English is limited, use of education materials such as those developed by the College, and efforts to mitigate patient stress (27, 30, 31). Most important is the acknowledgment that informed consent is an ongoing process, not an event or a signature on a document, and involves a willingness on the part of the obstetrician–gynecologist to engage in open, nonjudgmental, and continued dialogue.

Determine the Patient's Decisional Capacity

A pregnant woman's decision to refuse medically necessary treatment may occasion questions regarding her decisional capacity. Patients are, by law, presumed to be decisionally capable unless formally determined otherwise. The obstetrician–gynecologist should not infer from a patient's decision to refuse treatment that the patient's capacity to make medical decisions about proposed care is diminished. Disagreement with a physician's recommendation is not, per se, evidence of decisional incapacity. Although psychiatric consultation may justifiably be sought when a pregnant woman's decision-making capacity (ie, her capacity to understand her options and appreciate the potential consequences of her choice) is in question, in no circumstance should a psychiatric consultation be used as a punitive measure or viewed as a means to coerce a patient into making a specific decision. Genuine differences in how obstetrician–gynecologists and patients assess and balance risk; the pregnant woman's assessment of the collective interests of herself, her fetus, her family, or her community; and religious beliefs and cultural meanings of interventions may all lead decisionally capable patients to choose options other than those strongly recommended by their obstetrician–gynecologists (25). When a patient has been determined to lack decisional capacity, the decisions of her legally authorized surrogate generally should be honored. Such decisions should reflect the patient's previously expressed values and preferences when these are known.

Emergency Cases

Decision making can be particularly difficult and emotionally charged in emergency scenarios (32). Emergency cases may raise two distinct problems. First, fully informing the patient may not be possible. Nevertheless, a patient retains the right to make an uninformed refusal. Even if the patient has not been fully informed, a decisionally capable adult patient's refusal of emergent care should be respected. Second, the patient may be incapacitated and, therefore, unable to consent for herself. "Presumptive consent" for critically needed care for a patient can sometimes be used, but only if it is critically necessary to proceed with care immediately (33) and a patient's preference is not known. Use of presumptive consent is limited to emergency clinical situations in which the patient is completely decisionally incapable and no surrogate decision maker is reasonably available. Presumptive consent applies to cases in which an unconscious patient has not indicated a preference for treatment. Circumstances should support a reasonable presumption that the patient would retrospectively endorse the intervention. Expressions of disagreement or unwillingness preclude presumptive consent (33). A previously documented or expressed refusal should be respected.

Evaluate Maternal and Fetal Risk

Risk assessment during pregnancy poses unique challenges to patients and physicians. Interventions recommended during pregnancy and childbirth may reflect distortions of risk based on concerns about failure to intervene rather than robust considerations of risks associated with those interventions (34). Risk assessment in the context of a pregnant woman's refusal of recommended treatment should address concerns regarding

the respective benefits of the procedure to the pregnant woman and the fetus, the probability of harm to the pregnant woman and the fetus from either performing or withholding the procedure, and the risks and benefits of less intrusive treatments, when available.

Interdisciplinary Team Approach

Obstetrician–gynecologists are encouraged to resolve differences by using a team approach that recognizes the patient in the context of her life and beliefs and to consider seeking advice from ethics consultants when the clinician or the patient feels that this would help in conflict resolution. The team may include colleagues from other disciplines, such as nursing, social work, chaplains, or ethics consultation. With the patient's consent, it also may be helpful to include in the discussion members of the pregnant woman's personal support network. However, these individuals cannot make the decision for the decisionally capable patient. Obstetrician–gynecologists are encouraged to consider seeking an ethics consultation and to discuss the clinical situation with their colleagues. A team approach can help increase the likelihood of realliance with the patient by underscoring that the patient's concerns are shared among the health care team and her personal support system, particularly when the patient is included in the decision to use this collaborative approach.

Supporting the Patient and the Health Care Team When Adverse Outcomes Occur

When adverse outcomes occur after a pregnant patient's decision to refuse recommended treatment, she may feel guilty about her decision, and members of the health care team may experience frustration and moral distress about whether they took all possible preventive measures. As with any adverse outcome, it is important that the patient and health care team members engage in honest communication and receive compassionate support.

Resources and counseling should be made available to patients who experience an adverse outcome after refusing recommended treatment. Patients can be reminded that medical decision making is complex and that well-intentioned people can make decisions they regret. The fact that the adverse outcome was not a certainty should be reinforced. Most critically, the clinical team's efforts should be directed toward helping the woman with any grief that she may experience. Judgmental or punishing behaviors regarding the patient's decision can be harmful.

Resources also should be established to support debriefing and counseling for health care professionals when adverse outcomes occur after a pregnant patient's refusal of treatment. Medical practitioners can be reminded that respecting and supporting patients' autonomy is a core ethical principle, even when it involves risk of adverse outcomes. Clinician grief and anger are understandable, but these feelings need to be processed outside of interactions with the patient. As with any adverse outcome, debriefing in a supportive context should be undertaken to identify any measures that would help in future cases.

Conclusion

One of the most challenging scenarios in obstetric care occurs when a pregnant patient refuses recommended medical treatment that aims to support her well-being, her fetus's well-being, or both. Such cases call for an interdisciplinary approach, strong efforts at effective medical communication, and resources for the patient and the health care team. The most suitable ethical framework for addressing a pregnant woman's refusal of recommended care is one that recognizes the interconnectedness of the pregnant woman and her fetus but maintains as a central component respect for the pregnant woman's autonomous decision making. This approach does not restrict the obstetrician–gynecologist from providing medical advice based on fetal well-being, but it preserves the woman's autonomy and decision-making capacity surrounding her pregnancy. Pregnancy does not lessen or limit the requirement to obtain informed consent or to honor a pregnant woman's refusal of recommended treatment.

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Refusal of medically recommended treatment during pregnancy. Committee Opinion No. 664. American College of Obstetricians and Gynecologists. Obstet Gynecol 2016;127:e175–82.

302 Ga. 616
Supreme Court of Georgia.

The STATE
v.
COHEN et al.

S17A1265
|
Decided: November 2, 2017

Synopsis

Background: Defendants, who were civil attorneys and their client, were charged with conspiracy to commit extortion, conspiracy to commit unlawful surveillance, and conducting unlawful surveillance. The Superior Court, Fulton County, Henry M. Newkirk, J., dismissed all counts. State appealed.

Holdings: The Supreme Court, Melton, P.J., held that:

defendants did not unlawfully threaten alleged victim, as required for extortion charge;

one-party-consent rule did not apply to shield defendants from criminal liability;

the one-party-consent rule only applies to intercepted wire, oral, or electronic communications, overruling *State v. Madison*, 311 Ga.App. 31, 714 S.E.2d 714;

secret video recordings took place in "private place," as required for unlawful surveillance charge; and

unlawful surveillance and one-party consent statutes are not unconstitutionally vague.

Affirmed in part, reversed in part, and vacated in part.

Nahmias, J., concurred in part, concurred specially in part, and filed opinion.

Blackwell, J., concurred specially and filed opinion in which Hunstein and Peterson, JJ., joined.

Grant, J., concurring specially in part and filed opinion in which Hunstein and Blackwell, JJ., joined.

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Attorneys and Law Firms

Paul L. Howard, Jr., District Attorney, Marc A. Mallon, Lyndsey H. Rudder, F. McDonald Wakeford, Assistant District Attorneys, for appellant. Brian Steel; Finestone, Morris & White, Bruce H. Morris; Jimmy D. Berry; Reid Thompson, for appellees.

Opinion

****864** MELTON, Presiding Justice.

***616** According to the briefs, Mye Brindle worked as a housekeeper and personal assistant to Joe Rogers, who was married. During her employment with Rogers, the two became involved sexually.[1] In June 2012, Brindle hired attorneys David Cohen and John Butters to represent her on a potential claim of sexual harassment. On June 20, 2012, without Rogers' knowledge or consent to be video recorded, Brindle allegedly used a "spy" camera to secretly record video of Rogers naked in his bathroom and bedroom, as well as video of a sexual encounter between Rogers and herself inside his bedroom. The video recording was delivered to attorney Cohen, and Brindle resigned from her position with Rogers. On or about July 16, 2012, Rogers received a demand letter from attorney Cohen relating to the potential sexual harassment claim that he and Butters were prepared to file on Brindle's behalf.[2]

After extensive civil litigation between Rogers and Brindle that is not relevant to the current appeal, on June 17, 2016, Brindle and her attorneys (hereinafter collectively referred to as the "defendants") were charged in the Superior Court of Fulton County with conspiracy to commit extortion under OCGA § 16-8-16 (Count 1), conspiracy to commit unlawful surveillance (Count 2), and conducting unlawful surveillance under OCGA § 16-11-62 (Count 3). Brindle was also charged individually with one additional count of conducting unlawful surveillance under OCGA § 16-11-62 (Count 4).[3] The indictment was largely based on the defendants' prior actions involving an alleged conspiracy to secretly video record and then actually record Rogers in the bathroom and bedroom of his home on June 20, 2012, and then sending Rogers the July 16, 2012 litigation demand letter. Through multiple motions filed on September 19, 2016 and October 19, 2016, the

defendants filed a general demurrer to dismiss the indictment against them and to have OCGA §§ 16-8-16 (a) (3),[4] ***617** 16-11-62 (2),[5] and 16-11-66 (a)[6] declared unconstitutional. Following a hearing, on November 30, 2016, the trial court issued an order granting the defendants' general demurrer to the indictment. After finding that the indictment failed to allege that the defendants had committed any crimes under the relevant statutes, the trial court went on to conclude that OCGA § 16-8-16 (a) (3) was unconstitutionally overbroad on its face, and further declared that OCGA §§ 16-11-62 (2) and 16-11-66 (a) were unconstitutionally vague because "persons of ordinary intelligence [could not] be expected to determine what is permitted and prohibited by these [two] statutes." Accordingly, the trial court dismissed all counts of the indictment against all of the defendants.

The State appeals from this ruling, and, for the reasons that follow, we conclude that (1) while the trial court properly dismissed Count 1 of the indictment, the trial court erred by reaching the constitutional issue relating to OCGA § 16-8-16 (a) (3) in support of this result; and (2) the trial court erred in dismissing Counts 2, 3, and 4 of the indictment and in concluding that ****865** OCGA §§ 16-11-62 (2) and 16-11-66 (a) are unconstitutionally vague. We therefore affirm the portion of the trial court's order dismissing Count 1 of the indictment, vacate the portion of the trial court order's finding OCGA § 16-8-16 (a) (3) to be unconstitutionally overbroad on its face, and reverse the portion of the trial court's order dismissing Counts 2-4 of the indictment.

1. The State contends that the trial court erred in granting the defendants' general demurrer to Count 1 of the indictment. We disagree.

"A general demurrer challenges the sufficiency of the substance of the indictment, whereas a special demurrer challenges the sufficiency of the form of the indictment. [Cits.]" Bramblett v. State, 239 Ga. 336, 337 (1), 236 S.E.2d 580 (1977).

The true test of the sufficiency of an indictment that will withstand

> a general demurrer is as follows: If all the facts which the indictment charges can be admitted [as true], and still the accused be innocent, the indictment is bad; but if, ***618** taking the facts alleged as premises, the guilt of the accused follows as a legal conclusion, the indictment is good.

(Citations and punctuation omitted.) Lowe v. State, 276 Ga. 538, 539 (2), 579 S.E.2d 728 (2003). We "review[ ] a trial court's ruling on a general ... demurrer de novo in order to determine whether the allegations in the indictment are legally sufficient." (Footnote and punctuation omitted.) Smith v. State, 340 Ga. App. 457, 459, 797 S.E.2d 679 (2017).

Count 1 of the indictment states that the defendants were being charged

> with the offense of CONSPIRACY TO COMMIT A FELONY O.C.G.A. § 16-4-8,[7] for the said accused, in the County of Fulton and State of Georgia, on the 6th day of June, 2012, did unlawfully, together, conspire to commit the crime of EXTORTION O.C.G.A. § 16-8-16, and at least one of those persons did an overt act to effect the object of said conspiracy, to wit:
>
> OVERT ACTS
>
> 1.
>
> On or about the 3rd day of June, 2012, JOHN BUTTERS, an attorney authorized to practice law in Georgia, contacted Thomas Hawkins, a private investigator, to arrange a meeting to discuss making a covert video recording of a wealthy individual without that person's knowledge or consent.
>
> 2.
>
> On or about the 4th day of June, 2012, attorneys JOHN BUTTERS and DAVID COHEN met with private investigators Michael Deegan and Thomas Hawkins at the offices of Hawk Private Investigations ("Hawk P.I.") in Fulton County to discuss making a covert video recording of a wealthy person inside his residence without that person's knowledge or consent. BUTTERS and COHEN did not reveal the name of the wealthy person.
>
> ***619**
>
> 3.
>
> At the conclusion of this meeting, Michael Deegan and Thomas Hawkins agreed to help JOHN BUTTERS and DAVID COHEN purchase the spy camera even after

expressly stating to BUTTERS and COHEN that it would be illegal to covertly record someone in their residence without that person's knowledge or consent.

4.

On or about the 6th day of June, 2012, attorneys JOHN BUTTERS and DAVID COHEN met with investigator Michael Deegan a second time at the offices of Hawk P.I. in Fulton County. Accompanying BUTTERS and COHEN to this meeting was a person they identified as their client "Sam" and another person they identified as "Sam's mother." The purpose of this meeting was to further discuss the making of a covert video recording of a wealthy individual without that person's knowledge or consent.

5.

At the conclusion of the meeting at the offices of Hawk P.I. in Fulton County, ****866** DAVID COHEN purchased a spy camera made to look like a cell phone and designed to create covert video recordings.

6.

On or about the 11th day of June, 2012, Michael Deegan delivered the spy camera to MYE BRINDLE, the person previously identified as "Sam," and showed her how to use it.

7.

On or about the 20th day of June, 2012, MYE BRINDLE secretly videotaped the victim, later identified as ***620** JOE ROGERS, without his knowledge or consent, naked in the bathroom of his residence at [his home address] in Fulton County.

8.

On or about the 20th day of June, 2012, MYE BRINDLE secretly videotaped JOE ROGERS, without his knowledge or consent, naked in the bedroom of his residence.

9.

On or about the 20th day of June, 2012, MYE BRINDLE secretly videotaped a sexual encounter between her and JOE ROGERS, without his knowledge or consent, which took place in the bedroom of his residence....

10.

On or about the 22nd day of June, 2012, MYE BRINDLE delivered the spy camera and the video recordings referenced in Overt Acts 7 through 9 to Michael Deegan.

11.

On or about the 22nd day of June, 2012, Michael Deegan had the video recording made by MYE BRINDLE of JOE ROGERS on June 20, 2012 placed on DVD(s) and then delivered the DVD(s) to DAVID COHEN in Marietta, Georgia.

12.

On or about the 16th day of July, 2012, DAVID COHEN sent a letter to JOE ROGERS threatening a lawsuit on behalf of MYE BRINDLE. Said letter stated that there were "[n]umerous audio and video recordings" of sexual harassment and abuse by ROGERS upon BRINDLE. This letter sought to settle the matter before public litigation so that Joe Rogers may avoid potential "media attention ... intrusive governmental investigations, Department of Justice, Attorneys General or SEC involvement, as well as civil and criminal charges...."

13.

On or about the 2nd day of August, 2012, JOHN BUTTERS, DAVID COHEN, and Hylton Dupree, attorneys for MYE BRINDLE met with Robert Ingram and Jeffrey Daxe, attorneys for JOE ROGERS, to discuss the claims listed in the July 16, 2012 letter addressed to ROGERS. COHEN played an edited video of the sexual encounter that was secretly recorded by MYE BRINDLE on June 20, 2012, in the bedroom of Joe Rogers' residence, without his knowledge or consent, at [his home address] in Fulton County. BUTTERS informed Robert Ingram and Jeffrey Daxe that MYE BRINDLE wanted "millions" of dollars to settle her claim.

14.

On or about the 2nd day of August, 2012, DAVID COHEN told attorneys Robert Ingram and Jeffrey Daxe that he possessed videos of other sexual encounters between JOE ROGERS and MYE BRINDLE. Said statements made by ***621** COHEN furthered the extortion plot by asserting that there was another embarrassing video of ROGERS, which would tend to subject ROGERS to even more contempt and ridicule.

15.

On or about the 14th day of September, 2012, mediation was held in which, JOHN BUTTERS, DAVID COHEN, and Hylton Dupree asked for twelve million dollars to settle MYE BRINDLE'S claims which they argued were supported by the June 20, 2012 video of JOE ROGERS taken without his knowledge or consent.

16.

On or about the 19th day of September, 2012, DAVID COHEN filed a civil lawsuit in Fulton County on behalf of MYE BRINDLE, which stated that BRINDLE "made audio and video recordings of some of the incidents of sexual harassment and battery" which occurred in Fulton County and at Sea Island in Glynn County, Georgia.

****867**

17.

On or about midnight of the 28th day of September, 2012, MYE BRINDLE and one of her attorneys went to the Atlanta Police Department, hours before a court order sealing the record in Cobb County took effect, to report that JOE ROGERS physically forced himself sexually upon BRINDLE on numerous occasions.

18.

On or about the 9th day of October, 2012, the Honorable Judge Susan Forsling of Fulton County State Court, questioned DAVID COHEN during a hearing about the existence of another covert videotape of JOE ROGERS and MYE BRINDLE engaged in a sexual encounter. COHEN responded that ROGERS was "[p]artially naked" in the videotape. Said statements made by COHEN furthered the extortion plot by asserting that there was another embarrassing video of ROGERS, which would tend to subject ROGERS to even more contempt and ridicule.

19.

On or about the 24th day of October, 2012, JOHN BUTTERS, DAVID COHEN, and MYE BRINDLE served discovery requests on JOE ROGERS asking him to admit that a ***622** particular video recording labeled as "Exhibit 1 hereto is a true and correct video recording of a sexual encounter involving ROGERS and BRINDLE at the Roger's [sic] Sea Island residence." Said request was made by BUTTERS and COHEN to further the extortion plot by asserting that there was another embarrassing video of ROGERS, which would tend to subject ROGERS to even more contempt and ridicule.

Said offense in the County of Fulton and State of Georgia —contrary to the laws of said State, the good order, peace and dignity thereof[.]

With respect to the alleged crime that formed the basis for the purported conspiracy under Count 1 in this case:

> A person commits the offense of theft by extortion when he *unlawfully* obtains property of or from another person by *threatening* to ... [d]isseminate any information tending to subject any person to hatred, contempt, or ridicule or to impair his credit or business repute.

(Emphasis supplied.) OCGA § 16-8-16 (a) (3). Accordingly, in order to be found guilty of conspiracy to commit extortion under Count 1, the defendants had to conspire to unlawfully obtain property by "threatening to ... [d]isseminate any information tending to subject [Rogers] to hatred, contempt, or ridicule or to impair his credit or business repute" and commit an overt act to effect the objective of obtaining property from Rogers. OCGA §§ 16-8-16 (a) (3) and 16-4-8. However, a review of the indictment reveals that, regardless of any of the alleged overt acts that could have otherwise shown the existence of a conspiracy to commit some other crime (see discussion in Division 2, infra), there was no agreement to unlawfully obtain property from Rogers by "threatening" him in this case in any manner that could serve as a proper basis for a charge of illegal extortion under OCGA § 16-8-16 (a) (3). As explained more fully below, for this reason, the allegations in the indictment are legally insufficient to support a charge of conspiracy to commit extortion.

The alleged threat in this case is covered in "Overt Act" number 12 of Count 1, which, again, states that

> [o]n or about the 16th day of July, 2012, DAVID COHEN sent a letter to JOE ROGERS *threatening a lawsuit on behalf of MYE BRINDLE*[, and that this] letter stated that there were "[n]umerous audio and video

> recordings" of sexual harassment and abuse by ROGERS upon BRINDLE. This letter ***623** *sought to settle the matter before public litigation* so that Joe Rogers may avoid potential "media attention ... intrusive governmental investigations, Department of Justice, Attorneys General or SEC involvement, as well as civil and criminal charges...."

(Emphasis supplied.) From the plain language of the indictment, the alleged threat here was to file a lawsuit against Rogers and use the video as evidence in a court of law in the context of possible litigation. The indictment does not allege any threat (express or implied) to release the information to anyone ****868** outside of the potential court proceedings if Rogers did not pay Brindle a certain amount of money.[8] Compare Flatley v. Mauro, 39 Cal.4th 299, 46 Cal.Rptr.3d 606, 139 P.3d 2, 21 (II) (B) (3) (2006) (attorney committed extortion under California law where he threatened "to publicly accuse [the defending party] of rape and to report and publicly accuse him of other unspecified [crimes] unless he 'settled' by paying" at least $1 million to the attorney's client).

However, because any threat to "[d]isseminate any information tending to subject [another] person to hatred, contempt, or ridicule or to impair his credit or business repute" could, in theory, amount to extortion under OCGA § 16-8-16 (a) (3), the language of OCGA § 16-8-16 could be read to be broad enough to include "threats" of public litigation as unlawful and extortionate actions that could subject a person to criminal liability under the statute. But, a threat of litigation, by itself, is not unlawful. For this reason, we find that, based on the authority of other courts that have examined similar issues, mere "threats to sue cannot constitute criminal extortion." United States v. Pendergraft, 297 F.3d 1198, 1205 (IV) (A) (1) (11th Cir. 2002). See also Buckley v. DIRECTV, Inc., 276 F.Supp.2d 1271, 1275-1276 (N.D. Ga. 2003) ("[T]he Court is not aware of any authority holding that a demand to settle a claim before pursuing litigation amounts to extortion. In fact, such demand letters do not fit the legal definition of extortion [under OCGA § 16-8-16 (a)]").

Our construction of OCGA § 16-8-16 (a) (3) is consistent with this Court's "duty to construe a statute in a manner which upholds it as constitutional, if that is possible." (Citation omitted.) Cobb Cty. Sch. Dist. v. Barker, 271 Ga. 35, 37 (1), 518 S.E.2d 126 (1999). Indeed, if a mere threat of legitimate litigation could serve as a proper basis for a charge of extortion, OCGA § 16-8-16 (a) (3) could be ***624** applied in an overbroad and unconstitutional manner that would run afoul of First Amendment principles protecting the right of individuals to petition the government for a redress of grievances. See Borough of Duryea v. Guarnieri, 564 U.S. 379, 387 (II), 131 S.Ct. 2488, 180 L.Ed.2d 408 (2011) ("The right of access to courts for redress of wrongs is an aspect of the First Amendment right to petition the government ... [and] the Petition Clause protects the right of individuals to appeal to courts and other forums established by the government for resolution of legal disputes") (citations and punctuation omitted). We decline to adopt such a broad and potentially unconstitutional construction of the statute.

Because the alleged extortion in this case was based on a mere threat to file a lawsuit, and because there is no allegation in the indictment that the threatened litigation itself was somehow unlawful, the defendants could admit to all of the allegations in Count 1 of the indictment and still be innocent of the crime of conspiracy to commit extortion.[9] ****869** See, e.g., Brown v. State, 322 Ga. App. 446, 455 (3), 745 S.E.2d 699 (2013) ("[E]xercising one's right to file a lawsuit, or ... conspiring with others to file a lawsuit, in and of itself, does not constitute a 'threat' as required to support the crimes [of influencing or threatening witnesses in official proceedings]"). Accordingly, the trial court properly granted the defendants' general demurrer to this ***625** Count. See Lowe, supra. In light of the trial court's proper conclusion that Count 1 of the indictment failed to sufficiently allege a crime against the defendants under OCGA § 16-8-16 (a) (3) as a matter of law, the trial court did not need to decide any issue regarding the constitutionality of OCGA § 16-8-16 (a) (3). See, e.g., Board of Tax Assessors v. Tom's Foods, Inc., 264 Ga. 309, 310, 444 S.E.2d 771 (1994) (It "is well established that this court will never decide a constitutional question if the decision of the case presented can be made upon other grounds") (citations and punctuation omitted). We therefore vacate that portion of the trial court's order purporting to declare OCGA § 16-8-16 (a) (3) to be unconstitutionally overbroad on its face.

2. The State also urges that the trial court erred in granting the defendants' general demurrer to Counts 2-4 of the indictment. With respect to these Counts, the State is correct.

Count 2 of the indictment charged the defendants with

> CONSPIRACY TO COMMIT A FELONY O.C.G.A. § 16-4-8, for the

> said accused, in the County of Fulton and State of Georgia, on the 20th day of June, 2012, did unlawfully, together, conspire to commit the crime of UNLAWFUL EAVESDROPPING OR SURVEILLANCE O.C.G.A. § 16-11-62, and at least one of [the defendants] did [one of the Overt Acts alleged in numbers 1-13 of Count 1] to effect the object of said conspiracy[.]

Count 3 charged the defendants with

> UNLAWFUL EAVESDROPPING OR SURVEILLANCE O.C.G.A. § 16-11-62, for the said accused, in the County of Fulton and State of Georgia, on the 20th day of June, 2012, through the use of a SPY CAMERA, a device, without the consent of all persons observed, did unlawfully record the activities of JOE ROGERS which occurred at [his home address], a private place, out of the public view[.]

Finally, Count 4 charged Brindle individually with

> UNLAWFUL EAVESDROPPING OR SURVEILLANCE O.C.G.A. § 16-11-62, for the said accused, in the County of Fulton and State of Georgia, on the 20th day of June, 2012, through the use of a SPY CAMERA, a device, without the consent of all persons observed, did unlawfully record the ***626** activities of KATHERINE MARIE MAYNARD which occurred at [Rogers' home address], a private place, out of the public view[.]

All of these Counts, whether based on a conspiracy involving a prior agreement and certain overt acts or based on direct violations of OCGA § 16-11-62, hinge upon whether the facts alleged would show a potential violation of or an agreement to violate OCGA § 16-11-62 (2). That statute states in relevant part that

> [i]t shall be unlawful for ... [a]ny person, through the use of any device, without the consent of all persons observed, to observe, photograph, or record the activities of another which occur in any private place and out of public view [except where certain statutory exceptions contained in subsections (2) (A)-(D) apply].

The defendants contend that no violation of OCGA § 16-11-62 (2) has been sufficiently ****870** alleged in the indictment because (a) the defendants did not have to seek the consent of all persons observed in the video created by Brindle in order to video record Rogers or any other person in his home; and (b) the video recording itself did not take place in a private place and out of the public view. Both of these contentions are unavailing.

a. OCGA § 16-11-62 (2) requires the consent of all persons who will be video recorded before such persons can be video recorded in a private place and out of the public view.

Under the plain language of OCGA § 16-11-62 (2), except when certain specific exceptions listed in the statute apply, a person cannot lawfully "use ... any device" to "photograph ... or record the activities" of others that occur in any private place and out of public view "without the consent of all persons observed." Setting aside for a moment the question whether the indictment sufficiently alleged that the video recordings here were made in a "private place and out of public view" (which we will address in Division 2 (b), infra), OCGA § 16-11-62 (2) states in no uncertain terms that "*all persons observed*" must consent to observational activities such as being *photographed* or having their own *activities* recorded with any device before someone else can legally record them through any means that allow them to be *observed*. (Emphasis supplied.) The statute is written in terms that cover the types of *observational* surveillance that involve the capturing of images of another person on a spy camera without that person's consent. Here, the indictment alleges

that Rogers and another person were video recorded with a hidden ***627** spy camera in Rogers' home without their consent. Because video recording someone in such a manner falls into the category of surveillance activities covered by OCGA § 16-11-62 (2), and because Brindle and her attorneys allegedly took actions to agree to make a secret video and actually video record others without the consent of all of the persons being recorded, the defendants' actions fall within the purview of OCGA § 16-11-62 (2) and any alleged conspiracy to violate that statute (assuming that the video recordings were made in a "private place and out of public view").

However, the defendants contend that they were not legally required to obtain the consent of "all" of the persons being video recorded as required by the plain language of OCGA § 16-11-62 (2). Instead, they claim that they only needed to obtain the consent of one of the parties being recorded (Brindle) to avoid criminal liability in light of Georgia's "one-party-consent rule" contained in OCGA § 16-11-66 (a). The defendants are incorrect.

OCGA § 16-11-66 (a) states that

> [n]othing in Code Section 16-11-62 shall prohibit a person from *intercepting a wire, oral, or electronic communication* where such person is a party to the *communication* or *one of the parties to the communication* has given prior consent to such interception.

(Emphasis supplied.) By its terms, OCGA § 16-11-66 (a) applies to intercepted "communications," such as voices involved in a telephone conversation or an electronic communication to which the intercepting person is a party. See Fetty v. State, 268 Ga. 365 (3), 489 S.E.2d 813 (1997); OCGA § 16-11-66 (a). The statute does not refer to observational surveillance such as video recording or photographing another person's activities, and it does not apply to nullify the clear statutory requirement of OCGA § 16-11-62 (2) that the consent of *all* parties is needed before a person may use any sort of spying device to photograph or video record the activities of another person in a private place and out of the public view. See Gavin v. State, 292 Ga. App. 402, 664 S.E.2d 797 (2008) (one-party-consent rule of OCGA § 16-11-66 did not apply to prevent prosecution of defendant for violation of OCGA § 16-11-62 where defendant did not obtain consent of person he video recorded). OCGA § 16-11-66 (a) only applies to intercepted wire, oral, or electronic *communications*, and does not authorize the creation of any secretly produced photograph or video of *observed activities* without the consent of all persons being photographed or ***628** video recorded in a private place and out of the public view. [10] See ****871** Sims v. State, 297 Ga. 401 (2) n.2, 774 S.E.2d 620 (2015) (recognizing distinction between audible communication in recording that is subject to one-party-consent rule and video recording that is not). To the extent that the Court of Appeals' decision in State v. Madison, 311 Ga. App. 31 (2) (a), 714 S.E.2d 714 (2011), can be read to support the conclusion that the one-party consent rule of OCGA § 16-11-66 (a) can apply to video recordings made without the consent of all persons observed in private places and out of the public view, the case is overruled.

The indictment here does not fail based on OCGA § 16-11-66 (a) because the one-party-consent rule does not apply in this case to shield the defendants from potential criminal liability for conspiring to and creating a secret video recording of others with a hidden camera in an ostensibly private place and out of the public view without the consent of those other people whose activities were being recorded.

b. The indictment sufficiently alleges that the video recording took place in a private place and outside of the public view.

As stated above, pursuant to OCGA § 16-11-62 (2), a person may not use any device "to observe, photograph, or record the activities of another which occur in any private place and out of public view" without the consent of all persons being observed. Despite the fact that the indictment here indicates that the video recording in this case took place at a private home, outside of the public view, and without the consent of all persons recorded, the defendants contend that the recording could not have taken place in a "private" place because Rogers could not have had any expectation of privacy in a place in which he had allowed Brindle to enter for purposes of carrying on a sexual relationship with her. We disagree.

At the time Brindle secretly video recorded Rogers and another person in Rogers' home in June 2012, a "private place" for purposes of OCGA § 16-11-62 (2) was defined as "a place where one is entitled reasonably to expect to be safe from casual or hostile intrusion or surveillance." See

former OCGA § 16-11-60 (3). [11] Based on the indictment as written, and based on the plain language of the former ***629** version of OCGA § 16-11-60 (3), both Rogers and the other person who was secretly video recorded in the residence in this case would have had a reasonable expectation to be safe from "hostile intrusion or surveillance" in the places where they were video recorded. The indictment also indicates that all video recording activities took place in spaces within the residence that were outside of the public view. Accordingly, for these reasons alone, the places involved in this case would meet the statutory definition of "private place[s]" that were "out of public view." OCGA §§ 16-11-62 (2); 16-11-60 (3).

Although there is nothing in the plain language of former OCGA § 16-11-62 (2) to indicate that Rogers and the other person in the residence would no longer have a reasonable expectation to be safe from the "hostile intrusion" of having their activities secretly video recorded once Brindle entered the residence, and although there is nothing in the former version of OCGA § 16-11-62 (2) to show that the reasonable expectation to be safe from "hostile intrusion or surveillance" under the statute is coextensive with one's "reasonable expectation of privacy" under the Fourth Amendment to the United States Constitution, we have in the past looked to Fourth Amendment jurisprudence as a guide when interpreting the scope of privacy protected by OCGA § 16-11-62. See Burgeson v. State, 267 Ga. 102 (3) (d), 475 S.E.2d 580 (1996). [12] See also ****872** Quintrell v. State, 231 Ga. App. 268 (1), 499 S.E.2d 117 (1998). This may be the case, in part, because the language from the former version of OCGA § 16-11-62 (2) tracks much of the language from the Model Penal Code, which states that a " '[p]rivate place' means a place where one may reasonably expect to be safe from casual or hostile instrusion or surveillance, but ***630** does not include a place to which the public or a substantial group thereof has access." Model Penal Code § 250.12 (1). Later commentaries to the Model Penal Code give further context to the meaning of "private place":

> [T]he notion of a "private place" focuses on the presence of a reasonable expectation of privacy rather than the generic category of location. In doubtful cases, it is left to the court to determine in functional terms whether the [surveillance] occurred in a "private place" sufficient to invoke the provisions of [the anti–surveillance statute].

Model Penal Code Part II Commentaries, vol. 3, at 434.

In this regard,

> the application of the Fourth Amendment depends on whether the person invoking its protection can claim a "justifiable," a "reasonable," or a "legitimate expectation of privacy that has been invaded...."This inquiry ... normally embraces two discrete questions. The first is whether the individual, by his conduct, has exhibited an actual (subjective) expectation of privacy—whether ... the individual has shown that he seeks to preserve something as private. The second question is whether the individual's subjective expectation of privacy is one that society is prepared to recognize as reasonable ...—whether ... the individual's expectation, viewed objectively, is "justifiable" under the circumstances.

(Citations and punctuation omitted.) Smith v. Maryland, 442 U.S. 735, 740 (II) (A), 99 S.Ct. 2577, 61 L.Ed.2d 220 (1979). See also Katz v. United States, 389 U.S. 347, (88 S.Ct. 507, 19 LE.2d 576) (1967).

For Fourth Amendment purposes, one who begins with a reasonable expectation of privacy in a particular area such as his or her residence can lose that expectation of privacy by inviting a guest into that otherwise private place. See, e.g., United States v. Davis, 326 F.3d 361 (2d Cir. 2003) (defendant did not have reasonable expectation of privacy to prevent being video recorded with hidden camera in jacket of confidential informant after inviting confidential informant into his residence to sell drugs to the informant). [13] However, a person does ****873** ***631** *not* lose one's reasonable expectation of privacy simply when he or she invites a family member or someone who is more akin to being a member of the household into a place where one has a reasonable expectation of privacy. See Kelley v. State, 233 Ga. App. 244 (2), 503 S.E.2d 881 (1998) (sixteen-year-old girl had a reasonable expectation of privacy against her own family members when she was passed out nude in the family's home bathroom in the act of or following bathing). See also OCGA § 16-1-3 (15) (defining "public place" as used in Title 16 as "any place where the conduct involved may reasonably be expected to be viewed by people *other than members of the actor's family or household*") (emphasis supplied).

Here, the indictment as written does not establish that Brindle was not a member of or akin to being a member of Rogers' household; it indicates that Brindle was not a stranger or casual guest to Rogers or the residence in Fulton County where the alleged video recording took place. In fact, the indictment emphasized that Brindle's attorneys allegedly had "[n]umerous audio and video recordings" of sexual encounters between Brindle and Rogers; [14] that Brindle was expected to have the ability to make a "covert video recording of [Rogers] inside his residence"; that there were "videos of other sexual encounters between [Rogers] and [Brindle]"; that Brindle was able to make "audio and video recordings of some of the [sexual] incidents ... which occurred in Fulton County and at Sea Island in Glynn County, Georgia"; that there may have been "another covert videotape of [Rogers] and [Brindle] engaged in a sexual encounter ... [where Rogers] was '[p]artially naked' "; and that Brindle had another "embarrassing ... video recording of a sexual encounter involving [Rogers] and [Brindle] at [Rogers'] Sea Island residence." These allegations do not point to the activities of someone who was a stranger to Rogers or the residential address at which the surreptitious video recording is alleged to have occurred. To the contrary, the indictment shows that Brindle and Rogers were involved to a point where Brindle may have been the type ***632** of household member who could be allowed into Rogers' residence without Rogers or the other members of the household losing their reasonable expectation of privacy in those areas of the home that they intended to remain private. See Moses v. State, 328 Ga. App. 625, 628 (2) (a), 760 S.E.2d 217 (2014) (homeowner did not lose reasonable expectation of privacy "by allowing persons such as household residents, family members of residents, or housecleaners access to the house"). [15] Accordingly, even when we use the Fourth Amendment as a guide, the indictment here sufficiently alleges that the video recording took place in a "private place." The fact that the indictment also indicates that these areas were outside of public view is sufficient to satisfy the requirements of OCGA § 16-11-62 (2). Because the indictment here alleged facts showing that the defendants could be found guilty of the crimes charged in Counts 2-4 based on a conspiracy to violate, and the actual violation of, OCGA § 16-11-62 (2), the trial court erred in holding otherwise.

3. The trial court also erred in concluding that OCGA § § 16-11-62 (2) and 16-11-66 (a) are unconstitutionally vague. "A statute is unconstitutionally vague if it fails to give a person of ordinary intelligence notice of the conduct which is prohibited and encourages arbitrary and discriminatory enforcement. [Cit.]" Johnson v. State, 264 Ga. 590, 591 (1), 449 S.E.2d 94 (1994). As explained more fully in Division 2 (a), supra, there is nothing unclear about the requirement in OCGA § 16-11-62 (2) that "all" persons being observed must give their consent to be photographed or video recorded before ****874** such persons can be photographed or video recorded in a private place and out of public view. Nor is it unclear that the one-party-consent rule of OCGA § 16-11-66 (a) does not apply to eliminate the requirement for "all" persons to give their consent to be legally photographed or video recorded in a private place and out of the public view consistent with the requirements of OCGA § 16-11-62 (2). People of ordinary intelligence can understand that they can be found guilty of illegal surveillance if they use a device to secretly photograph or video record others in private places and out of the public view without the consent of all persons being photographed or video recorded, and neither OCGA § 16-11-62 (2) nor OCGA § 16-11-66 (a) encourages arbitrary or discriminatory enforcement of their respective provisions.

***633** Judgment affirmed in part, reversed in part, and vacated in part. All the Justices concur, except Hunstein, Nahmias, Blackwell, Peterson, and Grant, JJ., who concur specially.

NAHMIAS, Justice, concurring in part and concurring specially in part.

I concur fully in Divisions 1, 2 (a), and 3 of the Court's opinion. As for Division 2 (b), I agree with the Court's result but not all of its reasoning. It should be emphasized as to the result that we are now reviewing a general demurrer to the indictment, which limits us to the allegations of the indictment and requires us to treat them as true. With regard to the unlawful surveillance charges we allow to stand, the analysis might be different if we ever consider a full evidentiary record after trial.

Most significantly, I have serious doubts about looking even for guidance to modern "reasonable expectation of privacy" Fourth Amendment jurisprudence in interpreting the *pre-2015* statutory language defining a "private place" for purposes of OCGA § 16-11-62 (2) as "a place where one is entitled reasonably to expect to be safe from casual or hostile intrusion or surveillance." See former OCGA § 16-11-60 (3). That language was approved by the General Assembly in April 1967, see Ga. L. 1967, pp. 844, 852, and appears to be based on similar language in § 250.12 (1) of the 1962 Model Penal Code. It clearly did not refer to the revolution

in Fourth Amendment jurisprudence that occurred only later that year, when in December the United States Supreme Court ushered in a new standard for determining the reach of the constitutional privacy protection and first used the term "reasonable expectation of privacy" in Katz v. United States, 389 U.S. 347, 360, 88 S.Ct. 507, 19 L.Ed.2d 576 (1967) (Harlan, J., concurring). See United States v. Jones, 565 U.S. 400, 405-406, 132 S.Ct. 945, 181 L.Ed.2d 911 (2012) (discussing the "deviation" from the traditional property-based approach to Fourth Amendment jurisprudence aligned with common-law trespass doctrine that was effectuated by Katz's "reasonable expectation of privacy" approach). See also Hudson v. State, 127 Ga. App. 452, 455, 193 S.E.2d 919 (1972) (Hall, P.J., dissenting) (using the phrase "reasonable expectation of privacy" for the first time in a Georgia appellate decision).

Nevertheless, without acknowledging the real roots of former OCGA § 16-11-60 (3), this Court and the Court of Appeals have looked to modern Fourth Amendment case law to determine the scope of the protection against surveillance devices provided by OCGA § 16-11-62 (2), as the Court's opinion explains. We need not decide today if doing so is really appropriate, because the end result in this case, at least on general demurrer, is the same. And this Court may never need to ***634** resolve the issue, because in 2015 the General Assembly redefined "private place" in OCGA § 16-11-60 (3) as "a place where there is a reasonable expectation of privacy," thereby abandoning the Model Penal Code formulation and squarely invoking the modern Fourth Amendment test. See Ga. L. 2015, p. 1046, § 1.

I do not agree with everything said in the text and footnotes of Division 2 (b), but it reaches the right result, so I concur specially in that portion of the Court's opinion.

Blackwell, Justice, concurring specially.
I do not agree with all that is said in the opinion for the Court, and so, I do not join it. I do agree, however, that the indictment is not sufficient to survive a general demurrer ****875** with respect to conspiracy to commit extortion because it does not allege that Mye Brindle and her lawyers conspired to *unlawfully* obtain property from Joe Rogers by means of a threat to disseminate embarrassing information. See OCGA § 16-8-16 (a) (3). Although the indictment alleges that Brindle and her lawyers demanded that Rogers settle certain claims and threatened to sue him if he did not, there is no allegation that the threatened lawsuit was baseless (much less that Brindle and her lawyers knew it to be baseless), nor is there any allegation that the settlement demanded had no reasonable connection with the threatened lawsuit. [1] A proper application of the extortion statute is enough to resolve this case, and we need not address the First Amendment.

As for the unlawful surveillance counts, I agree that they survive a general demurrer. Irrespective of whether Rogers had a reasonable expectation of privacy under the Fourth Amendment in the place in which he was subjected to video recording, it appears from the facts alleged in the indictment that he had a reasonable expectation that he would not be subjected to casual or hostile photographic or video ***635** surveillance in that place. The State has adequately alleged that Rogers was in a private place under former OCGA § 16-11-60 and OCGA § 16-11-62 (2).

I am authorized to state that Justice Hunstein and Justice Peterson join this special concurrence.

GRANT, Justice, concurring specially in part.
While I do not agree with all that is said in the Division 2 (b) of the Court's opinion (and thus cannot join it), I do agree in full with the following statement: "[T]here is nothing in the former version of OCGA § 16-11-62 (2) to show that the reasonable expectation to be safe from 'hostile intrusion or surveillance' under the statute is coextensive with one's 'reasonable expectation of privacy' under the Fourth Amendment to the United States Constitution." Maj. op. at 629, 807 S.E.2d 861.

It is also true that we and the Court of Appeals have looked to the Fourth Amendment as a guide in interpreting the statute, but we have done so in remarkably different circumstances than the ones before us today. In both *Burgeson v. State*, 267 Ga. 102, 475 S.E.2d 580 (1996) and *Quintrell v. State*, 231 Ga. App. 268, 499 S.E.2d 117 (1998), *government agents* were alleged to have illegally surveilled criminal defendants. In that context, it is no surprise at all to look toward the Fourth Amendment, which serves as a constitutional boundary to the behavior of the government. But here, in analyzing the actions taken by private parties, the Fourth Amendment provides something less than a useful guide; in fact, applying Fourth Amendment rules may even serve to confuse rather than clarify the meaning of the statute. [1]

To begin, much of what the majority applies as seminal Fourth Amendment law had ****876** not yet been announced by the United States Supreme Court at the time that OCGA §

16-11-62 was drafted. See Ga. L. 1967, pp. 844, 852. The "private place" definition at issue here was passed by the General Assembly in April 1967, while the United States Supreme Court did not issue its *Katz* decision until December of that same year. See *Katz v. United States*, 389 U.S. 347, 88 S.Ct. 507, 19 L.Ed.2d 576 (1967). And the *Smith v. Maryland* decision that the majority quotes and applies was not issued until more than a decade ***636** later. See 442 U.S. 735, 99 S.Ct. 2577, 61 L.Ed.2d 220 (1979) ("In determining whether a particular form of *government-initiated* electronic surveillance is a 'search' within the meaning of the Fourth Amendment, our lodestar is *Katz v. United States*, 389 U.S. 347, 88 S.Ct. 507, 19 L.Ed.2d 576 (1967)." (emphasis supplied)). Relying on these cases leads to the odd conclusion that perhaps if Ms. Brindle had been a stranger rather than a guest, her surveillance would have been lawful. Maj. op. at 631, 807 S.E.2d 861. Or, perhaps, that Mr. Rogers would have had a lessened expectation of privacy for the same activities in Ms. Brindle's home rather than in his own. Id.

The statute cannot bear the weight that the Fourth Amendment puts on it when addressing the behavior of private parties and not of the government. In fact, the one Georgia case cited to support the potential distinction between privacy from strangers and privacy from family members or other close parties, is one that specifically concluded that "there is almost a total lack of authority" addressing parental wiretapping, which was the closest Fourth Amendment analog that the court could identify. *Kelley v. State*, 233 Ga. App. 244, 248-249, 503 S.E.2d 881 (1998). The court instead looked to an earlier Georgia case interpreting OCGA § 16-11-62 without any reference at all to the Fourth Amendment. Id. (citing *Ransom v. Ransom*, 253 Ga. 656, 324 S.E.2d 437 (1985)).

Nor am I as certain as my colleague that when the General Assembly redefined "private place" to constitute "a place where there is a reasonable expectation of privacy," the legislature was "squarely invoking the modern Fourth Amendment test." Concurring op. at 634, 807 S.E.2d 861. (Nahmias, J. concurring in part and concurring specially in part). Perhaps Fourth Amendment tests are more relevant under the new version of the statute—or perhaps not. After all, the amended statute still addresses a privacy interest quite different than the one that we all share against government search and seizure. But we need not make that determination until the proper case is before us, and I would decline to do so here.

I am authorized to state that Justice Hunstein and Justice Blackwell join in this concurrence.

All Citations

302 Ga. 616, 807 S.E.2d 861

Footnotes

1 The parties dispute the extent to which this relationship was consensual. Rogers claims that the relationship was consensual, whereas Brindle went to police in late September 2012 to report that Rogers had forced himself upon her sexually on numerous occasions.

2 The demand letter does not appear in the record.

3 Count 4 of the indictment, relating only to Brindle, involved the recording of another individual who was also at Rogers' home on the day that Brindle was recording the sexual encounter with Rogers.

4 "A person commits the offense of theft by extortion when he unlawfully obtains property of or from another person by threatening to ... [d]isseminate any information tending to subject any person to hatred, contempt, or ridicule or to impair his credit or business repute."

5 "It shall be unlawful for ... [a]ny person, through the use of any device, without the consent of all persons observed, to observe, photograph, or record the activities of another which occur in any private place and out of public view [except where certain statutory exceptions contained in subsections (2) (A)-(D) apply]."

6 "Nothing in Code Section 16-11-62 shall prohibit a person from intercepting a wire, oral, or electronic communication where such person is a party to the communication or one of the parties to the communication has given prior consent to such interception."

7 "A person commits the offense of conspiracy to commit a crime when he together with one or more persons conspires to commit any crime and any one or more of such persons does any overt act to effect the object of the conspiracy."

8 In this regard, we note that the remaining Overt Acts mentioned in Count 1 that deal with the creation and existence of alleged secret recordings and efforts to settle the case before commencing litigation also do not contain any agreement to threaten Rogers with the release of the recordings outside of litigation.

9 This is not to say that a charge of extortion could not be "based on intentional falsehoods or on knowingly frivolous claims." See Bill Johnson's Rests. v. NLRB, 461 U.S. 731, 743 (III) (B), 103 S.Ct. 2161, 76 L.Ed.2d 277 (1983) ("The first amendment interests involved in private litigation ... are not advanced when the litigation is based on intentional falsehoods or on knowingly frivolous claims") (footnote and punctuation omitted). However, where private litigation is not based on such intentional falsehoods or the like, a demand letter that merely threatens a lawsuit in connection with that potential litigation could not serve as a proper basis for a charge of extortion, as a party's right to pursue such litigation is protected by the First Amendment. See Borough of Duryea, supra. Here, again, there is no allegation in the indictment that the legal grounds supporting the threatened litigation in this case were based on intentional falsehoods or that the lawsuit was otherwise somehow unlawful such that the protection typically afforded to private litigation by the First Amendment right to petition the government for a redress of grievances would no longer be available. Thus, we need not decide any issue in this case relating to potentially baseless litigation, as that question is not properly before us based on the indictment as written. See Davis & Brandon v. Seaboard A. L. R. Co., 136 Ga. 278, 282, 71 S.E. 428 (1911) ("We think it would be a bad precedent to have the decision of this court invoked upon mere theoretical questions"). If, however, the defendants had been charged with threatening baseless litigation as a means of unlawfully obtaining property from Rogers, although this might serve as a proper basis for a charge of extortion, the defendants would still have an opportunity to defend against such an accusation at trial by proving that they had an honest claim to the property in question. See OCGA § 16-8-16 (c) ("It is an affirmative defense to prosecution based on paragraph ... (3) ... of subsection (a) of this Code section that the property obtained by threat of accusation, exposure, legal action, or other invocation of official action was honestly claimed as restitution or indemnification for harm done in the circumstance to which such accusation, exposure, legal action, or other official action relates or as compensation for property or lawful services").

10 In this regard, OCGA § 16-11-66 (a) would apply to those aspects of OCGA § 16-11-62 that deal with, for example, a person consenting to the recording of a conversation to which he or she was a party. See, e.g., OCGA § 16-11-62 (1). However, the allegations in this case do not deal with electronic or other "communications," but with video surveillance that would not be subject to the one-party-consent exception created by OCGA § 16-11-66 (a).

11 The statute was amended in 2015 to define "private place" as "a place where there is a reasonable expectation of privacy." OCGA § 16-11-60 (3).

12 This is *not* to say, however, that our analysis of one's reasonable expectation to be safe from "hostile or intrusive surveillance" under the former version of OCGA § 16-11-62 (2) is *limited* to the parameters set forth in Fourth Amendment jurisprudence. Indeed, the Fourth Amendment is concerned with stopping unauthorized intrusion by the *government* by *any* means into areas where a person has a reasonable expectation of privacy, whereas OCGA § 16-11-62 (2) is concerned with stopping unauthorized intrusion by *all* persons through the *specific* means of non-consensual photographing or video recording of their activities. It may very well be true that a person had a *greater* expectation to be free from the *specific* hostile intrusions of being video recorded or photographed under Georgia statutory law than he or she would have to be free from government intrusion for Fourth Amendment purposes. However, we need not decide that issue in this case, as our analysis above ultimately reveals that, even with the Fourth Amendment as a guide, Rogers and the other person who was video recorded in the residence did not lose their reasonable expectation to be free from the hostile intrusion of being secretly video recorded after Brindle entered the residence. Nor do we need to determine whether, by amending the statute in 2015 to define "private place" as "a place where there is a reasonable expectation of privacy" (OCGA § 16-11-60 (3)), the legislature intended for the definition of "private place" under OCGA § 16-11-62 (2) to only reference the "reasonable expectation of privacy" that one would have under the Fourth Amendment, as the language under the 2015 amendment is not at issue in this case.

13 We note that this case has nothing to do with a person inviting police or other government officials into his home by consenting to a search or for other purposes. However, to the extent that OCGA § 16-11-62 (2) could have been construed to apply to the actions of police officers making video recordings of others without their consent after being invited into someone's home, the legislature made clear through a 2015 amendment to OCGA § 16-11-62 (2) that police do not have to obtain the consent of all parties being video recorded in a private place and outside of the public view when they record such persons in connection with their duties as police officers. Pursuant to OCGA § 16-11-62 (2) (D):

> [I]t shall not be unlawful ... [f]or a law enforcement officer or his or her agent to use a device in the lawful performance of his or her official duties to observe, photograph, videotape, or record the activities of persons that occur in the presence of such officer or his or her agent.

14 We note that, although the indictment alleges that Brindle's attorneys *characterized* the relationship between Rogers and Brindle as non-consensual, the indictment does not state that this characterization was true or that the actual sexual

relationship between Rogers and Brindle was not consensual. If the indictment showed that the sexual relationship in this case was not consensual, our analysis might be different.

15 We need not address the Appellees' argument that Rogers no longer had a reasonable expectation of privacy because he was carrying on an adulterous relationship with Brindle, because there is no allegation *in the indictment* that the relationship between Rogers and Brindle was adulterous.

1 A simple hypothetical illustrates my understanding of the extortion statute. Like threats to disseminate embarrassing information, threats to accuse someone of a crime may, if used to obtain property from another, amount to extortion. See OCGA § 16-8-16 (a) (2). If I obtain property from you by threatening to call law enforcement and accuse you of a crime, it might be extortion, but not necessarily. If the property that I obtain is mine, I only threaten to accuse you of having stolen it, and the accusation is not baseless, there is nothing *unlawful* about my obtaining the property in question by means of the particular threat employed. On the other hand, if I obtain property from you to which I have no claim of right by threatening to accuse you of a crime (irrespective of whether the accusation is baseless)—"Unless you pay me $10,000, I will tell the police (truthfully) that you're a drug dealer"—it might be extortion. Likewise, if I obtain property from you (whether or not I have a claim of right to it) by means of a threat to falsely accuse you of a crime, knowing the accusation to be baseless—"Pay me back the money that you owe me, or I will tell the police (falsely) that you are a drug dealer"—it might be extortion.

1 Apart from the Fourth Amendment issues outlined more fully in this special concurrence, and in contrast to the majority opinion, I also note that the statutory text provides no reason that the recording of consensual and nonconsensual conduct would be treated differently under the statute. See Maj. op. at 631 n. 14, 807 S.E.2d 861. Additionally, one would expect that the indictment would include an allegation that the sexual activities at issue were consensual if that were an important factor in the interpretation of the statute–particularly where, as here, it was commonly understood that the activities were alleged by Ms. Brindle to be nonconsensual.